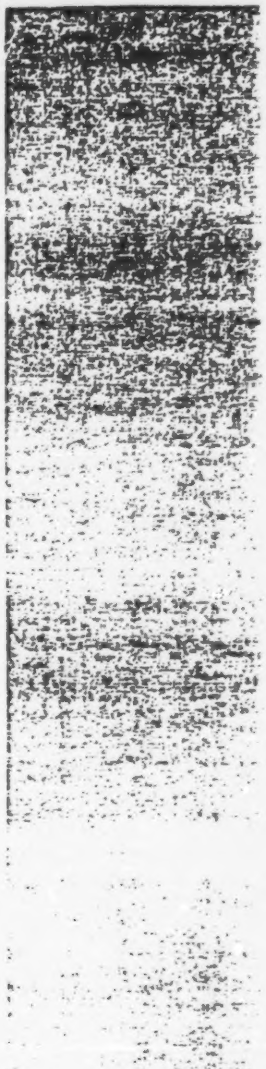

Health Care Financial Management and Accountability Review

Report to the Ministers of Health and Finance

April, 2000

HEALTH CARE FINANCIAL MANAGEMENT

AND ACCOUNTABILITY REVIEW

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HEALTH CARE FINANCIAL MANAGEMENT AND ACCOUNTABILITY REVIEW

INTRODUCTION

Following the release of Deloitte & Touche's interim report into the Manitoba Government's fiscal situation in December 1999, the Ministers of Health and Finance announced the establishment of a Health Care Financial Management and Accountability Review. The purpose of the review is to recommend effective cost control and management practices, as well as improved accountability measures, for the Department of Health and the regional health authorities (RHAs), while maintaining services to the public and ensuring health care dollars are spent on front line delivery and not on increased administrative costs.

The Terms of Reference for the review process are included under Appendix A.

REVIEW PROCESS

The review was carried out by Mr. Gordon Webster and involved consultation and discussion with a broad range of stakeholders within the health care sector. The purpose of the consultation process was to solicit input on the five focus areas identified within the Terms of Reference, both with respect to stakeholders' perception of how the health care system currently functions within Manitoba as well as suggestions as to how the system could operate on a more efficient and effective basis.

Although the focus of the review was primarily from a financial perspective, a number of observations and suggestions were received which, although not financial in nature, will have a positive economic impact on the system. The ultimate benefit from some of these recommendations will not be realized until improved information systems are in place, nevertheless there must be a commitment to action as soon as possible rather than waiting for *"all things to be in place"*. To this end, small working groups, comprised of representatives from appropriate stakeholders, should be established for each of the recommendations which are accepted and they should be given the mandate to develop implementation plans which can be initiated as soon as realistically possible. There must, however, be a recognition by all stakeholders that many of the recommendations would have to be phased in over a reasonable timeframe so as to ensure an orderly transition from a patient care perspective as well as a proper coordination of health care resources.

The following groups were involved in the consultative process:

- Regional Health Authority – Board Chairs
- Regional Health Authority – Chief Executive Officers
- Regional Health Authority – Labour Relations Secretariat
- Winnipeg Hospital Chief Executive Officers
- Winnipeg Regional Health Authority – Senior Management
- Winnipeg Regional Health Authority – Hospital Clinical Program Teams

- Winnipeg Regional Health Authority – Executive Directors of Personal Care Homes
- Winnipeg Regional Health Authority – Executive Directors of Community Agencies and Mental Health Agencies
- Manitoba Council of Health Care Unions
- Manitoba Medical Association
- Community Support Services for Seniors Group
- Allies for Health
- Manitoba Health - Senior Management
- College of Physicians and Surgeons of Manitoba
- Manitoba Association of Registered Nurses
- Manitoba Association of Licensed Practical Nurses
- Provincial Auditor and Senior Staff
- Secretary to Treasury Board
- Health Y2K Steering Committee
- Individuals who contacted Gordon Webster directly

In addition, a study was carried out of other financial management and accountability initiatives being undertaken elsewhere in Canada and all related material was reviewed for consideration in developing the recommendations contained in this report.

Finally, the findings from the consultation process and the recommendations were reviewed with an Advisory Committee established by the Ministers of Health and Finance. This Committee included:

Mr. Graham Lane – President's Office, University of Winnipeg

Professor Paul Thomas – St. John's College, University of Manitoba

Mr. Ron Hikel – Consultant to Manitoba Finance

It is important to recognize that the recommendations in this report are not all-inclusive and that many of the most significant changes which will be required to sustain our health care system in the future go well beyond the mandate of this review.

HEALTH CARE ENVIRONMENT

Health care in Canada has undergone substantial restructuring during the past decade, and this restructuring has created fundamental change in all parts of the health system. However, increasing costs related to continuing changes in the demographics of our population, medical advances, new pharmaceuticals and new technologies will necessitate continuing, and significant, evolution in the delivery and organization of health services in the future.

In researching the health care environment in Canada, information was obtained from the Canadian Healthcare Association (CHA) which is a federation of provincial and territorial regional authorities, hospitals, and health care facilities and agencies. The organization recently issued a discussion paper entitled *"Framework for a Sustainable Health Care System in Canada"* which is attached as Appendix B. This document outlines the challenges which we face in responding to the changing health needs of Canadians and a number of the initiatives which must be undertaken to facilitate the development of a sustainable health care system in Canada.

It is within this environment that the Manitoba government is facing ever-increasing financial pressures for health care services. As it will be impossible to avoid many of the changes which are driving these cost increases, it is absolutely essential that every initiative which will assist with system integration and management, in order to gain efficiencies and control costs, be pursued. Every change, however insignificant it may appear, must be implemented if it will have a positive economic impact on the system, as Manitoba cannot sustain future increases similar to those which have occurred during the past few years.

The following data highlights the challenges which we face. On a per capita basis, the Manitoba government's expenditure on health care services has risen from $1,622 in 1995 to $2,006 in 1999. This is an increase of almost 24% and leaves Manitoba with the highest per capita provincial health expenditure of any province in Canada. It is also important to note that the 1998/99 amount is based on 1999 forecasted expenditures and does not include the significant additional amounts committed to health care during the summer and fall of 1999.

Provincial government health expenditures, per capita:

Province	1994/95	1998/99	Change
Manitoba	$1,622	$2,006	$384
Quebec	1,746	1,639	(107)
British Columbia	1,719	1,963	244
New Brunswick	1.560	1,729	169
Saskatchewan	1,534	1,911	377
Nova Scotia	1,442	1,892	450
Alberta	1,288	1,806	518
Ontario	N/A	1,844	

Source:		
	1994/95 –	Health Reform Updates, Canadian College of Health Service Executives
	1998/99 –	Canadian Institute for Health Information, December 1999 health expenditures database

Appendix C includes other selected financial data, prepared by CIHI, in comparing Manitoba financial statistics with other provinces and Canadian averages. Manitoba Health is currently reviewing this data in order to obtain explanations for various differences in levels of costs as well as to identify possible inconsistencies in accumulation of the data.

ACCOUNTABILITY

The issue of accountability in health care is being addressed by various levels of government and health care organizations in Canada. In fact, the theme for the June 2000 National Healthcare Leadership Conference is "Accountabilities". Indicators that measure the performance of departments of health, regional health authorities, health care facilities and agencies, and physicians' services are now under constant development and review.

The CHA addresses the issue of accountability in their discussion paper, which is included in Appendix B. In addition, the CHA has developed a listing of all provincial documents on accountability in health care, by jurisdiction, and a review of this listing indicates the extensive work which has already been undertaken in looking at accountability from a wide variety of perspectives.

Three of the more detailed studies on accountability are:

- A discussion document finalized in late 1998 by Alberta Health, entitled *"Achieving Accountability in Alberta's Health System"*.
- A series of consultation sessions undertaken in Ontario, under the auspices of the Ontario Hospital Association, which will result in a joint hospitals/Ministry of Health and long term care accountability framework.
- A study on accountability mechanisms being conducted by researchers at Queen's University and the University of Toronto.

Various interpretations of accountability have been proposed as a result of the multitude of studies and reviews which have occurred across Canada. For purposes of this report, and specifically as it relates to financial accountability, the definition developed by Alberta is appropriate, namely *"the obligation to answer for the execution of one's assigned responsibilities to the person or group who conferred the responsibilities"*. The document goes on to explain that to be accountable, implies a formal relationship and it also implies a prior act of delegation direct from one party to another. This framework would exist between the Minister/Manitoba Health and the RHAs, and between the RHAs and non-devolved health care corporations or agencies. In these circumstances, for an accountability framework to function, it is important to focus on formal lines of authority – areas where responsibilities have been delegated, expectations clarified, reporting required, and performance evaluated. As noted in the Alberta document, several important elements underline effective accountability relationships:

- Roles and responsibilities are mutually understood and accepted;
- Performance expectations and outcome measures are explicit and mutually accepted;
- Sufficient resources, including authority to act, are provided;

- Review and feedback are carried out; and
- Follow up actions, including rewards and sanctions, may be taken to improve future performance.

The document goes on to state that delegation and authority are central to the concept of accountability. In summary, there can be no accountability without control. The individual conferring responsibility should monitor what is happening and step in if required – he or she has the authority to effect change if change is called for – a concept often referred to as sanctions.

Each of the recommendations contained in this report should be viewed from this perspective of accountability, and the roles and responsibilities for action of each stakeholder involved must be clearly defined. Without this clarification, it will be impossible to hold individuals or organizations accountable for their performance, or to take appropriate action when expectations of performance are not achieved.

Manitoba Health and the RHAs, through the Regional Health Authorities of Manitoba Inc., have an initiative underway dealing with the whole area of accountability as it relates to the relationship between the Minister and the RHAs and covers such issues as:

- achieving accountability – a draft framework
- governance accountability initiatives
- accountability monitoring process
- accountability mechanisms

The current Manitoba Health/RHA initiative should proceed as quickly as possible, utilizing all of the reference material already developed elsewhere in Canada as a resource, and it should also identify areas where shared accountability would be appropriate. The resultant material, which should identify accountability mechanisms and be approved by the Minister of Health, should then become an integral part of RHA Board member orientation sessions and should be included in a standardized Board evaluation process.

DRIVERS OF COST INCREASES

In consultation with the RHAs, an attempt has been made to determine what the main drivers are around increases in health care costs on a year-over-year basis. The purpose of this exercise was not to carry out a detailed cost variance analysis but rather to identify, from a high level perspective, the factors which are contributing to significant cost increases each year.

Winnipeg Regional Health Authority
Acute Care (Hospital) Services

The following summary has been prepared of hospital operating costs for three fiscal years ended March 31. It is extremely important to recognize that, although there are standard charts of account for hospitals, financial information within the WRHA hospitals has not previously been accumulated on a consistent basis. It is only with respect to the 1999/2000 projections that WRHA management have some degree of comfort around the consistency of data accumulation for all nine hospitals.

	1997/98 actual	1998/99 actual	1999/2000 projected
		(millions of $'s)	
Direct clinical program costs, including medical remuneration	$516	$554	$602
Indirect and other costs, including administration and facilities	177	192	220
Interest on approved borrowings and amortization of capital assets	73	70	71
Total operating costs, net of off-set revenue allocated to direct clinical programs	$766	$816	$893

Cost increases over the two-year period:

Direct clinical programs	$86	
Administration and facilities	28	
RHA costs	4	
Misericordia transition	2	
Y2K (subsequently reimbursed)	9	
Interest and amortization	(2)	
	$127	(17%)

Comments on cost increases:

- Of the $86M increase in direct clinical program costs over a two year period, approximately $30M to $35M relates to new and expanded programs, including the initial bed management initiatives, approved by Government between the spring of 1998 and summer of 1999.

- Wage settlements during the past year have added $22M to direct clinical program costs in 1999/2000.

- Drug costs in 1999/2000 are approximately $5M more than in 1997/98 while the new policy on single use devices increased costs in the range of $1.5M.

- Other cost increases related to clinical programs, amounting to approximately 3% per annum, are reasonably proportionate across all 13 clinical program areas and are said to relate to volume and cost increases, combined with the financial impact of an increase in the acuity level of patients and a shortened length of stay. The only exceptions are in the dialysis and surgery programs where the increases were relatively higher than other programs due to levels of activity.

- Administration and facility costs include food cost increases of $8.5M ($5M in 1998/99 and $3.5M projected for 1999/2000), salary and wage increases of $5M related to wage settlements, and a $2M increase in information technology costs.

- The balance of the increase in administration and facility costs amounts to $12M over two years, or approximately 3.5% per annum. This cost category represents a broad range of cost centres, the larger ones being housekeeping, laundry, plant operations and maintenance, security, food, information technology, health records and patient registration, utilities, executive office, human resources and personnel, planning, nursing administration and medical director's office.

The WRHA management believe that the 1999/2000 financial results will provide for a far more accurate and consistent base from which to measure comparisons with future years. However, until new financial management information systems are in place, detailed cost and volume analysis, required to manage a $1.2 billion operation on a more proactive basis, will not be available.

Winnipeg Regional Health Authority
Home Care Services

Home care consistently experiences the greatest amount of spending within the 65-85 age group. Thus, although the total population in Winnipeg has experienced a downward trend during the past three years, the population of 65+ has increased by approximately 2.5% with a corresponding increase in demand for home care services.

The following statistical information covers the three fiscal years ending March 31, 1997/98 to 1999/2000:

- the number of home care clients has increased by approximately 31%;
- the units of nursing service required by home care clients has increased by over 100% and units of support service has increased by over 38%;
- the number of clients in the community awaiting placement in PCH's has increased by 750 or 25%;

The cost drivers behind home care services in Winnipeg are therefore related to:

- increased number of individuals requiring the service;

- increased acuity over and above the number of clients, as evidenced by the significant increase in units of nursing service as well as clients awaiting PCH placement who, by their nature, require a higher level of care;

- increased cost of supplies, both in terms of volume and unit costs.

The WRHA has complete details in support of all the above home care information.

Brandon Regional Health Authority

The CEO of the Brandon Regional Health Authority has indicated that many of the drivers of cost increases in Brandon are similar to those in Winnipeg. These are summarized below:

- Increase in the acuity level of patients, which impacts not only the direct patient care costs but also indirect costs such as patient supplies, drugs and laundry.

- Drug costs, which are almost uncontrollable and cannot be budgeted to any degree of accuracy.

- Nursing overtime.

- Home care costs, primarily related to an increase in the number of individuals requiring home care services and, to some extent, also to increased acuity of home care clients who require an increased number of visits.

- Maintenance and repairs of aging equipment, including biomedical equipment, and aging facility structures.

- Volume increases, especially those related to clinical areas where the Authority has been successful in having physicians return to Manitoba, such as opthamology.

Rural Regional Health Authorities

The rural RHAs have confirmed that three of the principal drivers behind their increasing health care costs are:

- salary cost increases, related to recent contract negotiations, wage parity resulting from the Labour Board hearings, significant overtime costs to cover for severe staff shortages, use of agency staff also to cover for staff shortages, and increased salary levels for long-term staff;

- significant increases in home care services driven by both volume and acuity, as the result of an aging population, earlier discharges from hospitals, and maintaining waiting lists for people going into Personal Care Homes;

- patient transportation costs, driven by a variety of issues including salary costs associated with unionization, inability to operate with a "volunteer" staff, increased transfers for diagnostic testing, and increased transfers back from tertiary facilities.

In addition to the above, rural RHAs also identified the following factors:

- increasing levels of acuity because of an aging population, which in turn impacts every aspect of support services as well as direct clinical costs;

- rapidly escalating drug costs related to both volume and unit cost increases;

- unrealistically high maintenance and repair costs for aging equipment and facilities;

- increased supply costs, driven by volume, unit costs and the effect of foreign exchange on US-sourced supplies; and

- increased costs associated with the recruitment of physicians, nurses and other health care professionals into a rural setting.

PRIMARY RECOMMENDATIONS

During the consultation process, a number of specific issues were raised on several occasions by stakeholders and were repeatedly identified as areas where changes are required in order for cost controls or efficiencies to be achieved, or for financial accountability to function effectively. Although the direct link between several of the following recommendations and improved cost efficiencies may not be readily evident, nevertheless all of them, some indirectly, will have a positive economic impact in the future. A positive economic impact is considered to be any improvement which will help to avoid future cost increases, achieve costs savings, result in the system's ability to deliver improved or additional services utilizing the same resources, or for changes to occur on a positive basis from the perspective of all stakeholders.

1. **No later than December of each year, Manitoba Health should provide the RHAs with funding guidelines which can be utilized to prepare operating budgets for the ensuing fiscal year commencing on April 1. Final approved funding levels should then be confirmed immediately following Legislative approval of the Provincial budget. There must be a very clear understanding on the part of the RHAs of the health services which Manitoba Health expects them to provide with that funding. Manitoba Health and the RHAs have a mutual responsibility to ensure the RHAs have the operational capacity and resources to deliver those services within the funding levels provided.**

From a perspective of both financial management and accountability, this is the most critical, and consistent, recommendation identified during the review process.

Traditionally, many of the largest health care facilities in Manitoba have been provided with their approved funding levels within a timeframe which is well into the fiscal year. In addition, in many instances these funding levels have been inadequate for the health services which were to be provided during the year. Under these circumstances, it has been difficult, if not impossible, for the facilities to manage their financial resources appropriately – in the first instance because the funding level to which they should manage was unknown, and, secondly, because everyone at a senior level within a facility believed that the funding was inadequate for the services to be provided and acted accordingly. As a result of these circumstances, health care facilities have traditionally incurred expenses in excess of their funding levels, following which Manitoba Health has provided financial support to cover these deficits. This approach to funding makes it virtually impossible for RHAs and individual health care facilities to be held accountable for expenditures which exceed funding levels, nor does it provide Manitoba Health with the opportunity of approving increased expenditures for health care services in advance of these services being provided and the related costs incurred. This approach, in effect, quite often penalizes good financial management and rewards mis-management, as opposed to a system which would provide incentives for operating efficiently.

Ideally, RHAs should be provided with final approved funding levels before the start of the fiscal year on April 1. However, the timing of Legislative approval of the Provincial budget normally makes this impossible. Therefore, the recommended alternative approach would at least provide RHAs with an indication of the funding which they could anticipate receiving and they could then manage to that funding level commencing with the start of the fiscal year, with final approval to follow as soon as possible. This would create an environment whereby the RHAs could be held fully accountable for any cost overruns or unapproved changes in levels of activity which are outside of the funding guidelines. It would also create an environment whereby RHAs would be required to advise Manitoba Health, in advance, of any situations which may require changes in the previously agreed to levels of service. This, in turn, would allow Manitoba Health to assess the need for these potential increases and approve any additional expenditures before they are incurred, with a need for Manitoba Health responses to be provided on a very timely basis. RHA boards and senior management would also have to understand that the incurrence of operating deficits or provision of unapproved levels of health care services would have serious negative consequences.

Under this approach, RHAs should likely allocate a portion of their approved annual funding into a contingency fund which they could utilize to cover minor deviations from planned service levels without having to deal with Manitoba Health on these items. The use of the contingency funds could then be reviewed, by Manitoba Health, on an annual basis to determine whether or not such expenditures warrant inclusion in subsequent years' funding.

Finally, a funding approach which considers the longer term fiscal requirements of the RHAs, rather than just focusing on a one-year time frame, must be developed. The current health planning process is based on a three to four year outlook whereas funding is provided on a year-by-year basis. While recognizing that Manitoba Health cannot make funding commitments beyond one year, a funding model which included some indication of the possible availability of funding, or fiscal targets, covering the same period as the health plans would not only enable RHAs to be more responsive to possible restrictions in future funding levels, but would also enable Manitoba Health to make longer term decisions around affordable health care services to be provided in the future.

2. **With implementation of regionalization complete, and the development of an accountability document by Manitoba Health, Manitoba Health must now complete its internal restructuring from an organization with an emphasis on delivery and operations to its newly defined role of setting policies and priorities, province-wide long-term planning, prescribing health services which must be provided, establishing delivery standards, developing evaluation mechanisms, monitoring performance and funding the provincial health care system.**

Virtually all stakeholders identified the inefficiencies which occur, and the confusion which results from, the duplication of management and operations which currently exists between Manitoba Health and the RHAs.

The publication entitled *"Achieving Accountability"* which was published by Manitoba Health in August 1999, Appendix D, outlines very clearly the responsibilities of the

Minister of Health (and through the Minister to the Department) and the RHAs under the terms of *The Regional Health Authorities Act*. These responsibilities must now be operationalized within the Department of Health and the Department restructured so that it can fulfill its new mandate. Because of the challenges which will be encountered during the restructuring process, and the need for input and buy-in from both internal and external stakeholders into the changes which must take place, it is strongly recommended that an independent consultant with experience in leading a large-scale change management process be engaged to coordinate this initiative. Employees impacted by these changes must also be provided with appropriate training so as to enable them to fulfill the new roles expected of them.

The current overlap of functions between Manitoba Health and the RHAs is not only an inappropriate use of resources from a cost perspective, but it also makes it virtually impossible to hold the RHAs accountable for the responsibilities assigned to them (both under the Act and in the accountability document) when Department employees continue to be involved in day-to-day operational issues. For a regional system to function effectively, the senior people who understand front-line health care within the RHAs, and who are accountable for ultimate outcomes, must be the ones entrusted to manage health care, with appropriate sanctions in place for non-performance.

The eventual change in the role of Manitoba Health will also necessitate that a process be put in place which will enable the Minister's Office to have direct contact with RHAs to exchange information on operational issues. As the Minister and the RHAs are both accountable to the public (see page 5 of Appendix D), there must be a mutual understanding and consistency around all health care issues being reported to the public.

3. **A task force, comprised of appropriate representatives from the RHAs, Manitoba's Health Care Unions and Manitoba Health, should be established to develop solutions to address many human resource related impediments to effective and sustainable change within health care.**

As noted previously, health care in Canada has undergone substantial restructuring during the past decade. However, continuing changes in the demographics of our population, medical advances and new technologies will necessitate continuing, and significant, evolution in the delivery and organization of health services in the future. Discussions with various stakeholder groups have identified a broad range of human resource related impediments to meaningful change and these issues must be addressed in order to create the positive work environment which will be critical to the success of all change initiatives in the future.

These issues, which must be addressed on a cooperative basis by all interested parties, include:

- The need to develop processes for consultation among various stakeholders before a crisis has taken place rather than the traditional process of consultation after the fact or once a crisis has taken place.

- The identification of both short and long term staffing needs and projections, and the development of recruitment, education, retention and manpower plans which are coordinated to meet these needs. The educational plans must ensure that health care graduates meet national standards.

- The implementation of processes, such as focus groups as opposed to large staff meetings, which will allow for meaningful consultation and input from a broad range of front-line health care staff on decisions which will impact direct patient care.

- The need for human resources policies to be set centrally (by RHAs) but implemented locally. If some health care facilities are to continue as independent, autonomous organizations (i.e. non-devolved), they must still adhere to common human resource policies so that all staff are treated equally. Inconsistencies between RHAs must also be avoided wherever possible.

- The need for consistent and appropriate management structures, wherever possible, among RHAs. A proliferation of management structures creates confusion for staff and can eventually result in inequities in how staff are treated, lack of consistent involvement of certain health care professions, inconsistencies in approach to patient care, uncertainty around decision-making processes, lack of authority/accountability within facilities, and lack of coordination between RHAs around management issues.

- The resolution of the current part-time and full-time staffing situation, and determination of how existing financial resources invested in such expenditures as staff overtime (some of which may be outside of collective agreement provisions) can be re-directed to the creation of permanent or full-time positions.

- The pros and cons of having staffing guidelines for various components of health care. Where such guidelines are appropriate, there is also a need for them to be reviewed on a regular basis, enforced across the system, and for inconsistencies/non-compliance to be followed up on a timely basis.

- The development of a common, province-wide RHA human resource and payroll system which would provide the statistical data required to manage health care human resources on the most effective basis possible.

- The need to address the difficulties and financial inequities which are encountered when contracting out either management or front-line staff positions.

- The need to strengthen human resources in the community sector, including appropriate funding and "*leveling*" of salaries, so as to help attract and retain staff in these areas. This matter is critical to the successful re-direction of services from the more expensive acute care sector into the community sector.

- The need to determine the most appropriate means of training health care workers in the future. Private sector training is likely more expensive, from an individual's perspective, however if this approach is the most effective for the system as a whole then some form of subsidies for staff should be considered. The most cost-effective means of upgrading or training existing staff, to enable them to assume additional responsibilities, should also be explored.

- The need for clarification, and likely expansion, of the role of the Labour Relations Secretariat and its relationship with individual RHAs. The current uncertainty as to *"who is responsible for what"* often creates a bottleneck in decision making, an excuse for inaction in human resource related matters, and confusion around collective bargaining issues. Central grievance handling, in addition to collective bargaining, through the Labour Relations Secretariat, would have a significant positive economic impact on the system and would provide for more timely and consistent approaches to all labour relations/grievance issues. Centralization of grievance handling would also free up individual RHA human resource staff to focus on local human resource issues. Finally, once the role of the Labour Relations Secretariat has been fully clarified, all RHAs must be mandated to utilize these resources, as one or two RHAs functioning on their own, or offside, can impact the whole province.

- The need for a province-wide Employee Assistance Program, similar to the one currently available to employees of the former Winnipeg Hospital Authority, is critical. There is no industry in Canada where employees are under the constant personal pressures which front-line health care workers face, and an effective Employee Assistance Program will not only provide support for staff but will also have positive economic impacts. With implementation of such a plan, processes must also be put in place to monitor and assess the human resource and economic benefits of the plan.

4. **The existing governance and corporate structure of the Winnipeg hospitals should be evaluated within the context of their relationship with the Winnipeg Regional Health Authority (WRHA) and the benefits which are being achieved under the current model versus the benefits which could occur under an alternate model.**

The current structure within Winnipeg, whereby individual hospital boards and senior management organizations were left in place when regionalization was implemented, is unique in Manitoba and, in fact, unique in Canada. It is the view of many senior leaders within healthcare across Canada that this model is not the most efficient, not only from a cost perspective, but also with respect to the possible lack of cooperation and duplication of effort which creates a significant waste of time on the part of limited management resources. This is a view which is also shared by many individuals within the various stakeholder groups which were consulted during the review process.

The current model evolved from the faith-based agreement, which was negotiated between government and the four faith-based hospitals in the fall of 1996. Many of the components of this agreement were then incorporated into the Operating Agreement which was entered into by all nine hospitals and the Winnipeg Hospital Authority in 1998. These Operating Agreements expire on March 31, 2001 and prior to that date a decision must be made as to the relationship which should exist between the hospitals and the WRHA in the future. The current uncertainty regarding future structures creates continuing unrest within the system and with staff. Management efforts are focusing on power and control as opposed to the economies of scale which could be achieved through delivery of clinical and support services on a truly regional basis, which in turn would allow for duplications in funding to be redirected to front-line patient care. Finally, the current model, which requires a complex structure of matrix management in order to function, makes it extremely difficult to delineate clear lines of responsibility and accountability.

There is a broadly-held view within many stakeholder groups that regionalization of health care services within Winnipeg, which will allow for the full integration of services across the full spectrum of acute, long term and community care, can have a very positive impact on health care services while at the same time achieving significant cost efficiencies. However, there is also a belief that this can only be achieved if the WRHA is given the tools to do the job in Winnipeg, and one of these tools is a significant increase in the Authority's responsibility for management of the Winnipeg hospital system on a fully coordinated basis.

In order for this to be achieved, a decision as to the future structure of the hospital system must be determined well before the current Operating Agreements expire. If a decision is made to leave hospital boards and senior management organizations in place, then government must mandate that the WRHA's role be strengthened to provide the WRHA with the authority it requires to manage a system with a $1.2 billion annual operating budget and for which it is accountable. Some of the conditions which could be considered include:

- Having hospital CEOs/COOs accountable to the WRHA CEO around all matters of an operational nature.
- Having the WRHA Board Chair sit on hospital CEO/COO selection committees and having hospital CEO/COO compensation packages ratified by the WRHA Board. The WRHA Board Chair should also have access to annual hospital CEO/COO performance evaluations.
- Providing funding to the hospitals only to a level which would be required if the hospitals merged into the WRHA. All Board-related expenditures and management positions other than those required of a merged facility, would have to be funded by the hospitals out of ancillary revenues.
- All support services should be restructured and delivered on a regionalized basis. This does not imply that all staff would be centralized, but rather services would be run as a single initiative under the leadership of an

individual or team who would have responsibility for that service across the Winnipeg hospital system.

- All services which are outsourced or tendered, such as insurance, audit and legal, should be purchased or tendered jointly through the WRHA, rather than by individual hospitals, in order to achieve economies of scale.
- As turnover occurs at the CEO/COO level, explore the possibility of having CEOs/COOs responsible for more than one facility.

If a decision is made to merge the publicly-owned hospitals into the WRHA, then a partnership agreement similar to the one which exists between the Saskatoon Health District Board and St. Paul's Hospital could be considered as a model for the WRHA's relationship with the faith-based facilities. A copy of an article dealing with the Saskatoon partnership model is attached as Appendix F.

With respect to the management of the hospital sector in Winnipeg, the following reviews should also be carried out. These will have two benefits – firstly to ensure the system is functioning as cohesively and efficiently as possible, and secondly to respond to any critics who may have concerns about overlaps or duplication in the system.

- an in-depth operational review of all levels of management structures to ensure consistency between facilities (where appropriate), to identify areas of duplication or inefficiencies, and to identify functions which could be more appropriately provided on a regional basis. Common job descriptions and performance evaluation criteria should also be an output from this review;
- an assessment of staffing utilization, patterns and models to ensure the most efficient approaches are being followed by all facilities. This assessment could then lead to common position control systems for all facilities, detailed payroll budgets and bi-weekly payroll reports; and
- a review of management structures within clinical program areas to ensure consistency across the system and to ensure there is no duplication between facilities and the WRHA program teams.

5. **Urban Shared Services Corporation (USSC) should be merged into the Winnipeg Regional Health Authority (WRHA) as soon as possible. Concurrent with this move, the purchasing function should be centralized and managed as one service within the WRHA.**

The current corporate structure of USSC, which was reasonable at the time the organization was founded, no longer makes sense under a regionalized model of health care delivery. Merging the operations into the WRHA not only allows a more integrated model with the resultant benefits of critical mass, but it also moves the service into the organization which is more directly accountable to the Minister for performance under the provisions of *The Regional Health Authorities Act*.

The centralization of the purchasing function also has added economic benefits. USSC currently acts as the contract-negotiating arm for WRHA hospitals, however, individual hospitals still maintain their own purchasing functions. Although the supply chain has consolidated in Canada, the Winnipeg hospitals have not responded to these changes. There are now small numbers of very large customers buying from a smaller number of very large suppliers. In this environment, volume rebate and corporate alliance programs have been established however, with the Winnipeg system purchasing on a hospital-by-hospital basis, they have not been able to take advantage of many of these programs. For example, one major supplier indicated that the hospital system missed out on an opportunity for a $500,000 rebate last year because of the disjointed purchasing processes currently being followed in Winnipeg.

There are a number of excellent examples of purchasing program models functioning in Canada, with very clear and limited lines of authority and accountability. One of the best examples identified by several suppliers was London Health Sciences Centre and a visit to this location may provide the WRHA with an indication of how to structure a centralized purchasing program for the region.

6. There must be a much closer integration of funding decisions where both capital and operating dollars are involved.

It is not unusual for operating expenditure decisions or capital expenditure decisions to be made in isolation of each other in instances where there are significant financial implications on both sides. In order to avoid this situation, there must be much closer integration of functions within the Capital Planning Branch and Operations Branch of Manitoba Health, in conjunction with RHAs. The following processes should be considered:

- Capital projects should not move beyond the contract document stage before it is confirmed that related operating funding will also be available.
- The operating dollar impact of all capital decisions should be clearly identified.
- A strong business case, including cost benefit analysis, should be developed for all capital expenditures over a specified dollar level.
- Capital equipment replacement decisions should take into account operating dollar impacts. For example, the operating dollar impacts of maintaining old equipment, including repairs and maintenance, very often exceeds the cost of replacing equipment.
- Capital incentives should be made available which will encourage RHAs to identify projects for which significant operational saving can be identified and achieved.

7. **A review should be carried out of all rural hospitals in the Province to determine the need for these hospitals and, where appropriate, the alternate uses to which these capital assets could be redirected.**

There is a view that, in some parts of the Province, there are too many acute care beds and that the dollars currently being directed to these services could be more effectively utilized for community based care. There is also a view within some RHAs that there is adequate funding already available provided the system could be reconfigured to provide "the right services in the right place".

In order to adopt this recommendation, RHAs would have to be given the responsibility and authority to make the tough restructuring decisions without political interference, other than with the final approval of Manitoba Health and the Minister of Health. The Minister would also have to approve the criteria under which the reviews would be carried out.

8. **The existing RHAs within the Province should be reviewed to determine whether mergers of some RHAs would be more economical or would enable the delivery of improved levels of patient care.**

This review would not necessarily relate to a question of saving money but would allow RHAs to provide better services if they had the critical mass necessary at the senior management and clinical leadership levels. There is a view that some RHAs are not large enough to operate at the most effective or efficient level possible, nor do they have the resources necessary to offer the most appropriate quality standards.

This review would have to take into account such things as population base and travel patterns of patients. In the absence of any changes to the current number or structure of RHAs, the review may identify areas where there could be more inter-regional planning and service delivery at the clinical program level as opposed to that which is currently being achieved. This could be especially true in areas of specialty services where critical mass is essential in order to achieve appropriate levels of patient care and cost efficiencies.

9. **Manitoba Health must move aggressively, and effectively, in the development of performance measurement criteria to assess the performance of RHAs and the health care services which they provide.**

In a recent publication entitled "Accountability, Business Planning and Performance Measurement in Government", the Conference Board of Canada stated, "*measurement can highlight performance shortfalls, signal priorities, help set direction, identify areas for improvement, improve decision making, enhance communications, track social and economic trends, and help anticipate problems*". The document also indicates that building a sound planning system, identifying useful performance indicators and integrating measures effectively into the management of an organization are challenging in any context, and the nature of public service compounds the complexities. Nevertheless, extensive efforts must be made to identify measures that will shift the focus of government and RHAs from reporting on inputs, to reporting on results and outcomes that will reflect the value of health care services delivered. As stated in a recent National Post article, *"we need to know how many people became healthier through the money being spent and how long those people had to wait before receiving treatment."* We cannot currently answer those questions.

The identification of appropriate measurement criteria, in close cooperation with the RHAs, is one of the most challenging, yet critical, responsibilities which Manitoba Health must undertake. In order for accountability to function effectively, measurement criteria (of both a clinical and management nature) must exist and these measures will influence behaviours and choices, and will ultimately shape results within the health care system. Once the measurement criteria have been determined, and Manitoba Health and the RHAs are satisfied that they are the ones which will enable them to improve their efficiency and effectiveness, a process of reporting to the public must also be put in place. The documents released by the Toronto District Health Council in November 1999, reporting on a broad range of health indicators within the Greater Toronto Area, or The Hospital Report '99, a balanced scorecard for Ontario's hospitals prepared by the Ontario Hospital Association, could be used as examples in the development of a health report card.

Finally, it is also critically important that the measurement criteria not be developed in isolation but in conjunction with criteria being developed by other Provinces, health care providers, the Manitoba Centre for Health Policy and Evaluation and the Canadian Institute for Health Information.

10. Submissions for health care services outside of the normal regional health planning process should be avoided.

The purpose of the regional health plan is to identify regional priorities for health care services, and these priorities should be established based on the health care needs of the region and the funding which is available. Requests for health care services will arise outside of the regional health planning process, and the political priorities driving these requests quite often will be different from the needs-based clinical priorities. In order for RHAs to be held truly accountable for the clinical services being provided within their respective regions, they must have the capacity to manage outside of the political environment and avoid the resultant inequities in patient care services and cost overruns which will result when the normal planning process is circumvented.

11. Regional health plans should have a section which focuses on services which should be moved from acute care to the community.

Many outpatient programs currently being provided through the acute care sector could be provided more effectively, from both a patient care and cost perspective, in the community sector.

The business case which is developed for the movement of such services should take into account both the impact on patient care and the long-term financial implications. Where it can be demonstrated that such movement of services is beneficial, including from an operational cost perspective, transitional funding should then be made available for the initiatives, with RHAs being held fully accountable for the ultimate achievement of the benefits demonstrated in the business case.

12. **A cooperative process should be put in place, between Manitoba Health and the RHAs, to monitor and assess the impact of new technologies and new medical procedures, before the RHAs and Manitoba Health are required to make decisions around increased expenditures in these areas. This process should also establish criteria which should be followed in rationing treatment modalities and address the approach to dealing with the conflicts arising from limited resources. In fact, the process could lead to the development of specific recommendations to address individual situations when these conflicts occur.**

Advances in medical technologies and procedures are going to be very extensive during the next decade and many of these will be extremely costly and resource-intensive in nature. Governments and health care leaders will have to decide on the benefits of proceeding with many of these initiatives before health care providers start to implement or utilize them.

Guidelines should be established including reductions in morbidity, results of research or clinical trials, and protocols for new ways of doing business before any commitment is made to new funding. In developing the guidelines, consideration must be given to the ethical issues which we will face in adopting new technologies and procedures, when difficult choices around prioritization of services will have to be made.

This work must be undertaken at the provincial or RHA level, with appropriate input from health care professionals, as the unit of influence at the hospital level is too small, and yet that is where such assessments and decisions have been made in the past. These situations, which typically have occurred in the acute care sector, have usually precluded Manitoba Health's ability to make proactive decisions around the appropriateness of the increased expenditures.

13. **A process should be established to develop plans for reform of the primary health care system, including the development of policies to support new primary health care models.**

During the past ten years, extensive research has been carried out in Canada on the need to reform the primary health care system and many papers have been written on this subject. Throughout this time period, the system has continued to deteriorate and become dysfunctional, with the result that undue, and inappropriate, pressures have been placed on the acute care system. Although the approach to primary health care reform goes well beyond the mandate of this review, it was identified by many stakeholders as an essential element to improving the cost effectiveness of our health care system.

In order to start the process of effective primary health care reform in Manitoba, a task force comprised of appropriate representatives from the College of Family Physicians of Canada, Manitoba Association of Registered Nurses, the RHAs, and Manitoba Health should be established and charged with the responsibility of developing a blueprint for reform of the primary health care system, in its broadest sense, for the province of Manitoba.

This initiative is absolutely essential if we are to build a better health care system which will respond to the needs of Manitobans in the future, and will provide enhanced quality, accessibility and affordability within health care. It will result in "appropriate service providers providing the right service in the right setting", a more appropriate use of our existing acute care resources, a reduction in the number of patients being seen by physicians that could be treated by other health care professionals, and extended use of our existing resources in the community sector.

As the reform process is clarified and implemented, along with the development of alternate care delivery mechanisms in the community, the role of walk-in clinics, and the performance evaluation criteria and monitoring processes which are necessary, should be assessed.

14. **Finally, in order to achieve the maximum benefit from many of the recommendations contained in this report, and to allow for the effective day-to-day management of an extremely complex health care system which expends over $2 billion per annum, investment in sophisticated computer-based management and clinical information systems is absolutely essential.**

Considering the "age of technology" in which we now operate, and the broad range of health care related software applications which are available, it is difficult to justify the lack of technological support available within the RHAs. Although the tools available within the acute care sector may have been adequate in the past, by today's standards they are grossly inadequate to manage a complex, integrated, multifaceted operation. The situation in the community sector and many of the rural RHAs is even worse, where virtually no technological support exists, and where it does, it is based on obsolete technology, provides inadequate functionality, and in many cases no longer has vendor support.

When you contrast the current information technology environment within the RHAs with the information needs for effective management, performance measurement and accountability, it becomes very obvious that the data which is required to monitor and control health care expenditures, to manage waiting lists and waiting times, and to measure clinical outcomes, is not available either to Manitoba Health or the RHAs. The Conference Board of Canada has indicated that more effective use of data can be a powerful lever for future performance gains in the public sector. The Board further indicates that the currency of any accountability system is data, the language through which goals and targets can be articulated, activity monitored, performance assessed and impacts evaluated. The right data, well used, may not only strengthen government's accountability for results but significantly improve their efficiency, effectiveness and agility as high-performance organizations capable of delivering high-quality results. The Board outlines the following examples of the uses of data in best-practice organization, all of which are essential for the effective delivery of health care:

- To instill objectivity and rigor in decision making;
- As input to situation analysis, root-cause analysis and problem solving;
- To manage key processes;
- As an early warning signal of problems or emerging issues;
- To substantiate key operational messages;
- To give concrete realities to strategic goals and objectives through target setting;
- To track and communicate progress against targets.

A synopsis of the information system strategies of the Winnipeg Community & Long Term Care Authority and the Winnipeg Hospital Authority, prepared as a joint submission to government in April 1999, outlined the benefits to a healthcare system of the use of effective information systems. These benefits were summarized as follows:

- Direct costs savings, such as labour savings, less duplication, less wastage;
- Cost avoidance and the ability to avoid future expenditures;
- Service benefits, such as the ability to provide more timely, more appropriate service, or to provide the service with fewer errors, clearly significant in a health care setting.

The submission referred to above is included as Appendix E, and outlines on pages 5 through 13 the benefits of effective information systems to the consumer, to the health care system, and to government.

The RHAs, in conjunction with Manitoba Health, have established a Task Force to develop a Provincial IT Strategy on the use of information technology in Manitoba's health care sector, based on the WCA/WHA synopsis, the Brandon Regional Health Authority's plan, and plans underway within the rural RHAs and Manitoba Health. The Province's Chief Information Officer is also providing input to the process. It is vitally important that the initiatives outlined in this strategic document proceed as quickly as possible.

Until such time as the provincial plan can proceed, local initiatives should continue. However, common technology standards must be developed and adopted immediately by all RHAs in order to avoid future incompatibility of systems and duplication in training efforts. Within Winnipeg the following interim initiatives could be implemented and could later be integrated with a provincial solution, what ever way it is structured:

- operate IT as a single support service with city-wide IT leadership;
- centralize payroll services using a common payroll system;
- redirect the fees currently being paid to Ceridian, which is utilized by six Winnipeg hospitals, to acquire an HR system;
- restructure the HSC IT department to a central processing operation for payroll, HR and clinical systems. Remove HSC identity, consolidate staff as necessary, and expand to a 24-hour operation with Help Desk and training support.

OTHER RECOMMENDATIONS

In addition to the primary recommendations, which were the focus of a broad range of stakeholders during the consultation process, a number of other suggestions were raised. While these may not have the same degree of unanimity amongst stakeholders, nevertheless, many of them are as equally important in addressing financial management, control and accountability within Manitoba's health care sector. The multitude of other recommendations which were raised also reflects stakeholders' views on the number of changes which must be made in order for the system to function more effectively. In some instances, there may also be overlap in several recommendations.

Recommendations arising from other matters noted, presented in no particular order of importance, are:

- Guidelines should be established for new programs before these programs are implemented. For example, apparently in the expanded WCA stroke program, therapists were instructed to increase hours of service without being provided with details of improved outcomes which would be expected from the increased commitment of resources.
- Plans should be developed which will aggressively sell health care as a profession that is attractive to young people.
- In establishing plans for leveling of salaries, comparisons must also be made with the private sector, which is attracting front-line staff from health care. Examples here include pharmacists and therapists.
- Investments in new quality initiatives should be made only after it can be demonstrated that the individual initiatives will either improve the quality of patient care or result in care being provided on a more cost-effective basis.
- Aggressively pursue other sources of revenue for the health care sector, particularly if underutilized resources can be used for this purpose. Examples given related to services for life insurance companies, the transportation industry, and clinical trials for various industries.
- The significant investment which has been made in contingency planning in such areas as flood preparation, strike preparation, and Y2K should be capitalized on for the future. Rather than let these plans become outdated, they should be integrated and maintained on a current basis, so as to avoid the need for similar resource-intensive planning initiatives when similar contingencies occur in future years.
- The information technology procurement process developed by government during the Y2K exercise should be maintained. This process was one of the most cost effective and responsive procurement processes ever followed, and these benefits should not be lost, but maintained and built on.

- Proper fixed asset management systems should be developed, as soon as possible, to track and control the RHAs very significant investment in computer, biomedical, and physical plant equipment. Such systems will enable the RHAs and Manitoba Health not only to properly account for dispositions of such equipment, but also to ensure that insurance coverage is adequate and that long-term planning around equipment maintenance and replacement can be facilitated. This information was gathered during the Y2K inventory process and is now available for the first time ever within Manitoba's health care sector. If new fixed asset management systems are not put in place immediately, the long-term benefits which can be realized from the costly Y2K inventorying process will be lost.

- The community health assessment process should be used more effectively as a guide for establishing priorities in the development of regional health plans. Community health assessments are at varying degrees of evolution across RHAs, and once a credible assessment process is in place, the results thereof must form the basis of priority-setting for regional health plans. The consultative approach which is part of the community health assessment process should also involve increased public debate around the major issues facing health care in Manitoba and the difficult choices which will have to be made in the future around priority setting.

- A strong internal audit function should be established within the two major RHAs, namely Winnipeg and Brandon. These functions, which must go beyond the normal financial audit function to include both operational auditing and value-for-money auditing, will generate financial paybacks well in excess of the costs of establishing them, as well as resulting in a far more effective use of existing resources. This will be particularly true in the operational auditing and value-for-money auditing areas. The Provincial Auditor's Office should be involved in establishing the value-for-money component of the service.

- An infrastructure diagnostic analysis should be carried out of all nine hospitals in Winnipeg to evaluate the buildings from a structural perspective. This information can then help to determine the best use for these facilities in the future. This initiative will not only provide the WRHA and Manitoba Health with a more accurate indication of the long-term funding required for safety and security issues, new or expanded programs, and infrastructure replacement, but will also be integral to the development of a city-wide hospital bed plan as services are moved from the acute care sector to the community sector, and help identify the most appropriate location for ambulatory programs when they are developed.

- A process should be put in place to assess performance of various models of regionalization being followed in Canada. Approximately 10 years ago, an environmental scan of health care determined that more effective management models were required, and regionalization was adopted across the country, albeit following different models from province to province. These models are working to various degrees of success and a regular review would enable Manitoba Health to determine which ones are working better than others which, in turn, would allow for the Manitoba model to be adapted, wherever appropriate.

- The service purchase agreements, which currently exist between RHAs and various health care providers, should be reviewed to determine what is working and what is not, and the agreements should then be amended accordingly.

- It is essential that the coordination of efforts in providing health care services to First Nations communities be improved. These services are presently being delivered from four different sources, and must be better coordinated in order to achieve the maximum patient care benefits for the resources which are being invested.

- A business case approach should be followed before any new dollars are introduced into the system. Currently, new dollars are usually introduced in a totally isolated framework, sometimes on a piecemeal basis, as opposed to through a business case which incorporates all perspectives, including operational and capital funding requirements, future implications, and impacts on all related programs or services. This business case must be completed, and signed off by both the RHAs and Manitoba Health, before funding requests go forward to Treasury Board in order to avoid any surprises at a later date. Once approved, new programs should also be implemented under a standard program management approach.

- A process should be established to develop a long-term infrastructure replacement plan, including priorities, for all health care facilities in the province. Much of the current infrastructure is in a state of serious decay and in some instances is nearing the stage of being unsafe.

- Group purchasing is currently carried out under three programs, namely the RHAM program for Brandon and rural RHAs, the USSC program for the Winnipeg hospital system and Manitoba Distribution Agency. These programs should be reviewed to determine whether some type of integration would be more effective and to ensure the current structure is not resulting in volume discounts being minimized or lost.

- There are indications that the caseload of out-of-province patients being treated in the acute care sector is continuing to increase. A review should be undertaken of this situation to ensure inter-provincial billings for these services are appropriate considering the increasing costs for these services and that reasonable consideration, from a funding perspective, is being given to the RHAs providing them.

- As new standards are developed around quality of care, or new legislation is introduced which impacts delivery of care or health care management, full costing exercises should be carried out in advance so everyone has a clear understanding of the operational funding impacts, and to ensure that appropriate funding can be provided to RHAs to cover the related cost increases.

- RHAs should be provided with "seed money" or transitional funding to support initiatives related to health prevention or promotion. In order for this funding to be provided, a business case should be prepared, including research which outlines the potential benefits in the future and an indication of projected lessening of demand for direct health care services.

- A review should be carried out as to how extended hours of service (evenings and weekends) for clinics in both the acute care and community sectors would result in improved utilization of existing infrastructure resources, increased numbers of clinical procedures at lower per unit costs, and reduction in various waiting lists. The areas affected could be day surgery clinics, various community clinics and diagnostic equipment.

- A review should be carried out of the various policies for funding of pharmaceuticals. For example, the policy whereby drugs are an insured service while in hospital but not at home creates an environment whereby patients may be kept in hospital so their drug therapies can be paid by the hospital. These drug therapies are quite often the most effective treatment and could be given at home but are not, with the resultant inappropriate increase in all levels of acute care service costs.

- Caution should be exercised that, when the University of Manitoba's health care faculties face increased cost pressures, educational functions are not downloaded to the acute care hospital sector, with the resultant increase in costs within this sector.

- The capital equipment funding process should be streamlined. Cutbacks in funding for capital equipment, combined with significant variances in the annual allotments for capital equipment renewal, has resulted in much of the system's biomedical equipment become either obsolete or reaching a stage of serious deterioration. In these circumstances repairs and maintenance expenses become excessive, often exceeding the replacement costs of the equipment, and in some instances the equipment becomes unsafe from a patient care perspective. A stable and predictable pool of funding should be made available each year so that the health care providers can develop a rational, long-term replacement plan for this equipment. Considering the rapid evolution of technology, consideration should also be given to the pros and cons of leasing this specialty equipment which will become obsolete very quickly.

- An operational review of home care services being provided in Manitoba should be carried out. This review should focus on the cost effectiveness of the delivery model (including staff mix), the appropriateness of the services being delivered, integration with other service delivery components of health care, and the flexibility in utilization of existing funding to ensure maximum value for dollars expended.

- The future relationship of Personal Care Homes and Community Agencies with RHAs, and especially the WRHA, should be evaluated. The evaluation should cover such areas as governance and Board structures including funding thereof, and the ability of these organizations to share management or administrative resources. The current situation where non-profit PCH's come under the direction of RHAs while the for-profit PCH's come under the direction of Manitoba Health should also be reviewed to ensure that this segregation continues to be appropriate and does not result in conflicting levels of care or differences in application of standards. Ideally, the for-profit PCH's should eventually contract directly with the RHAs.

- As the process of restructuring the provincial lab system moves forward, the future role of Cadham Provincial Laboratory must be evaluated. Consideration should also be given to rolling-in the private labs as soon as possible so as to realize the significant financial savings which can be achieved by such a move.

- A comprehensive analysis and comparison should be undertaken of the current scopes of practice and competencies of both RN's and LPN's, and this information should be used in development of optimum staffing models. With the significant challenges being faced within both the acute care and community care sectors around nursing vacancies and pressures on nursing staff, it is essential that staffing policies and models be implemented which not only utilizes the skill sets of both groups to their greatest potential but also maximizes the cost effectiveness of the staff mix.

- Similarly an analysis should be prepared of the professional scopes of practice for the various allied health groups and compared with the clinical scopes of practice which they are undertaking within their working environment. Once again, the purpose is to ensure that the professional skills of these individuals are being utilized to the greatest extent possible.

- It is extremely important that we start to focus more on keeping people well so as to avoid continual increased demands on the health care delivery system. Accordingly, a small percentage of funding for continuing or new programs should be directed to initiatives which will assist with health promotion and disease prevention.

- There is a need for improvement in communications between various government departments around health-related issues. For example, several comments were received regarding Manitoba Housing developing housing complexes which cannot accommodate new health programs.

- There are a broad range of community services in place, especially for seniors, which have evolved over a period of time and which, prior to regionalization, have operated in isolation of each other. Through the RHAs there is now starting to be a much better coordination of these services as well as an identification of gaps in services and duplication of services. Many of these services have been developed by grass-roots community action groups and it will be important not to lose this individual creativity, energy and caring. Also, this component of health care relies to a much greater extent on volunteers than any other sector and the leverage effect of even relatively minor funding increases will significantly impact those service which will help keep people out of the traditional health care environment such as hospital, PCH's and clinics. Longer term planning must also now start to take place around these services and evaluation templates should be developed by RHAs in order to have comparable assessments of the various services so funding can be directed to those which have the greatest impact on the population affected.

- As the much-needed process for long-term planning around health care services is put in place, and because *The Regional Health Authorities Act* precludes the involvement of health care professionals at the governance level, it is absolutely essential that the planning framework be such that input from this important stakeholder group (including front-line staff) be solicited and fully considered.

- RHA communication strategies, especially the WRHA, should include a process to inform and educate the public about the services which are available in the community sector and explanations as to how to access these services.

- Greater emphasis should be placed on the public disclosure of financial information regarding the operating costs of health care services. This would have two benefits; firstly, providing the public with increased information on the cost of their personal health services would enable them to assess the value of what they are receiving relative to its costs and, hopefully, encourage them to manage their own health care more effectively. Secondly, it would ensure that RHAs, health care facilities, management and staff would become more accountable for efficient performance through increased public scrutiny of financial results.

CONCLUSION

As noted earlier in this report, it will be necessary to phase in those recommendations which are accepted over a reasonable timeframe as opposed to "trying to do everything at once". Nevertheless, considering the pressures currently facing the healthcare system, there is also a certain urgency attached to many of the recommendations.

In these circumstances the small working groups which are established to develop implementation plans must have a clear understanding of the need for expediency. Similarly, the implementation teams must also understand the need to meet predetermined timelines as well as the shared responsibility and accountability, which they carry, for successful implementation.

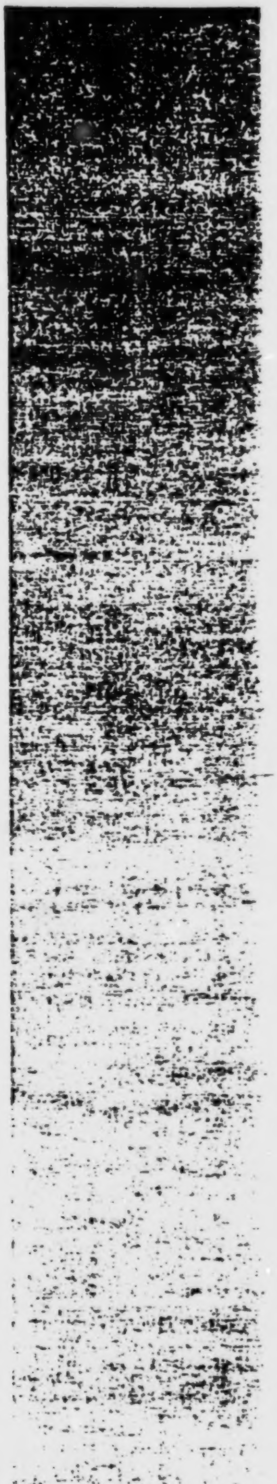
Finally, I would like to express my sincere appreciation to all stakeholders and the Advisory Committee for their advice and assistance in the development of this report.

Respectfully submitted,

Gordon B. Webster, FCA

April 2000

Appendices



HEALTH CARE FINANCIAL MANAGEMENT AND ACCOUNTABILITY REVIEW

Terms of Reference

A goal of the Government of Manitoba is to ensure that the maximum amount possible of available health care dollars are spent on front-line service delivery and not on duplicate or unnecessary administrative costs. The purpose of the Health Care Financial Management and Accountability Review is to recommend, directly to the Ministers of Health and Finance, effective cost controls and financial management practices, as well as approaches to financial accountability, for the Department of Health and the Regional Health Authorities while maintaining services to the public. It is recognized that this is a very significant area of challenge and concern for all levels of Government and health care providers in Canada. As such, the recommendations will not be all-exclusive, but rather the start of a continuing and evolving process.

The review will focus on the following areas, primarily from a financial perspective:

- The identification of any inefficiencies, overlaps or duplication, which exist within the planning for, and delivery of, health care services in Manitoba.
- The introduction of improved accountability around health care expenditures in Manitoba.
- The processes which must be implemented to avoid the traditional funding shortfalls and subsequent deficit "top-ups" which have characterized health care spending in Manitoba for a number of years.
- The processes which must be implemented to enable Government to make pro-active decisions around necessary increases in health care funding levels, before the expenditures take place as opposed to being faced with unapproved expenditure increases after the fact.
- Any suggested changes in our approaches to health care delivery which would help to alleviate the continuing upward pressures on health care expenditures.

In order to ensure appropriate input, and subsequent support for the recommendations, the review process will involve a series of interviews with a broad range of stakeholders within the Manitoba health care sector and Government, as well as researching initiatives being undertaken by other jurisdictions or organizations in Canada which are dealing with similar cost pressures and lack of accountability for health care expenditures.

December 17, 1999

Appendix B

CHA's Framework for a Sustainable Healthcare System in Canada

DISCUSSION PAPER

Prepared by the
Canadian Healthcare Association

November 1999

The sustainability framework outlined in this document was approved by the Board of Directors of the Canadian Healthcare Association (CHA) at their meeting in October 1999.

One of the purposes of this discussion paper is to encourage and facilitate public discussion and debate regarding our healthcare system and the necessary components for its sustainability as an innovative, integrated, accountable and publicly funded system.

This document is a work in progress. Your comments, questions and suggestions are encouraged and welcome.

Information regarding the Canadian Healthcare Association and *CHA's Framework for a Sustainable Healthcare System in Canada* can be obtained by contacting:

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EXECUTIVE SUMMARY

The Canadian Healthcare Association (CHA) is the federation of provincial and territorial hospital and health organizations committed to preserving and strengthening Canada's health system. CHA represents regional health authorities, hospitals, and healthcare facilities and agencies, which employ close to one million healthcare workers, and serve Canadians across the country. These organizations are governed by trustees who act in the public interest.

Today, through our member organizations, CHA represents a broad continuum of care, including: hospitals, long-term care facilities, home and community care agencies, community health services, public health, mental health, addiction services, housing services, child, youth and family services, and professional and licensing bodies. CHA's mission is to improve the delivery of health services in Canada through policy development, advocacy and leadership.

This framework for a sustainable healthcare system in Canada was developed by CHA's Board of Directors as a benchmark to ascertain if new initiatives for maintaining and improving the healthcare system in Canada are working collectively and cooperatively toward a common end — providing Canadians with the appropriate level of care by the appropriate caregiver at the appropriate time in the appropriate place. It is a framework not only for today, but also for the new millennium. It challenges individuals, organizations and governments to proactively engage in the future.

CHA's overall message of sustainability is important for a number of reasons, including to:

- Demonstrate that healthcare facilities and agencies are part of the solution. Healthcare managers and providers are committed to working with others to ensure that the healthcare system is responsive to the needs of Canadians and provides services in appropriate and innovative ways. The answer is not just more government money; health facilities and agencies must be champions and agents of effective change.
- Provide objective and clear reasons why there is still not enough money in the system — including the consequences of not securing adequate and long-term public funding.
- Establish that an investment in healthcare is an investment in productivity, innovation and knowledge development, as well as in the health of Canadians.
- Encourage and facilitate public discussion and debate regarding our healthcare system and the necessary components for its sustainability as an innovative, integrated, accountable and publicly funded system.

CHA's Framework for a Sustainable Healthcare System will be used by CHA and our provincial and territorial member organizations as the basis for a number of policy and advocacy initiatives.

Key Components of CHA's Sustainability Framework

The key components of CHA's framework for a sustainable, publicly funded healthcare system in Canada are:

1. Responding to the Changing Health Needs of Canadians
2. Realizing the Vision of an Innovative and Integrated System
3. Ensuring the Availability of Appropriate Health Human Resources
4. Developing and Implementing Appropriate Accountability Mechanisms
5. Advancing Health System and Health Services Research
6. Contributing to the Productivity of Canadian Society
7. Providing Sufficient and Long Term Funding

CHA's understanding of the prerequisites for effective change, the outstanding issues to be addressed, and the potential strategic investments related to each component of the sustainability framework are outlined in the discussion paper. Highlights of the potential strategic investments for each of the framework's key components are provided below.

Potential Strategic Investments

The CHA Board of Directors has identified a number of strategic investments, on the part of governments, healthcare managers and the general public, which will facilitate the development of a sustainable healthcare system in Canada. Details of these strategic investments are provided in the discussion paper.

Responding to the Changing Health Needs of Canadians

With our understanding of the determinants of health becoming clearer and the composition of the Canadian population constantly changing, our healthcare system must adapt if it is to be responsive and effective.

Potential strategic investments that will enable a sustainable healthcare system in Canada to be responsive to the changing health needs of Canadians include a focus on:

- Population Health
- Children's Health
- Aboriginal Health
- Rural, Remote and Northern Health
- New Technologies

Current and future changes in the demographic profile of Canadians are leading to changes in health conditions (more chronic conditions), care settings (home and community care and long term care), service delivery (realignment of hospitals) and the range of services (promotion, prevention, rehabilitation). Our current healthcare system is meeting a wide range of health needs. Dramatic shifts in health needs and technologies are requiring significant changes in the delivery and integration of health services.

CHA and our provincial and territorial members would welcome the opportunity to work with others to ensure that the healthcare system, now and in the future, is responsive to the health needs of Canadians.

Realizing the Vision of an Innovative and Integrated System

The health system for the new millennium will look and operate very differently from the health system that evolved in the 20th century. However, core public values must be maintained. CHA's vision is a publicly funded health system that provides access to a broad range of comparable health services across Canada.

Potential strategic investments that will enable the vision of a sustainable healthcare system to be realized include a focus on:

- Public Understanding and Debate Regarding Our Publicly Funded System
- The Canada Health Act
- Publicly Funded Home and Community Care
- Strategic Directions, Goals and Objectives
- Long Range Plans for the Organization and Delivery of Healthcare
- Sufficient and Long Term Funding
- Alternative Delivery Models

As we enter a new millennium, it is time for new ventures and visions — we need to build on the past and embrace the future. To encourage innovative and strategic actions to be taken, long range visions of organizational structures and delivery systems are needed. There is a window of opportunity now with the signing of the Social Union agreement and the Health Accord for provincial, territorial and federal governments to demonstrate their willingness and ability to work together to realize common visions and develop collaborative solutions for the challenges facing the healthcare system. Canadians expect nothing less.

CHA and our provincial and territorial members are committed to being integral partners in realizing the vision of a sustainable healthcare system that is innovative and integrated.

Ensuring the Availability of Appropriate Health Human Resources

A key component of ensuring a sustainable healthcare system is the availability of health human resources. CHA's perspective in terms of health human resources issues is not limited to the "employer" perspective: we are advocating from a "systems" perspective and from a "public interest" perspective to ensure that a responsive healthcare system can be sustained.

Potential strategic investments that will be needed to ensure the availability of appropriate health human resources include a focus on:

- A Health Human Resources Plan for Nurses
- A Health Human Resources Plan for Physicians
- A Health Human Resources Plan for Home Care Workers
- Shorter Term Initiatives
- Federal, Provincial and Territorial Funding

A futuristic health human resources plan is needed, one which considers new delivery models and health needs and does not consider individual provider groups in isolation. National as well as provincial and territorial initiatives are required to identify options and implement solutions. These solutions need to be identified and developed collaboratively with providers, employers, unions, consumers, and governments. No one group has the solution.

CHA and our member organizations look forward to working with other partners to identify the key issues, develop options and implement feasible solutions to the many health human resources issues that are testing the sustainability of our healthcare system.

Developing and Implementing Appropriate Accountability Mechanisms

Healthcare facilities and agencies are committed to providing clear, objective information regarding their effectiveness and efficiency in providing services and their impact on the health status of Canadians.

Potential strategic investments that will facilitate the development and implementation of appropriate accountability mechanisms include a focus on:

- Governments, Researchers and Healthcare Groups Working Together
- Support for National Health Infostructure Initiatives
- Federal Funding for Health Infostructures
- Sharing of Information
- Privacy and Confidentiality

Many accountability relationships must be honoured. These relationships, with responsibilities flowing in both directions, include: government-to-government, governments-to-providers, governments-to-Canadians, and providers-to-consumers. CHA's understanding of accountability is that the focus is not on the provincial and territorial governments being accountable to the federal government, nor on the tracking of dollars. Rather, the primary focus of accountability should be on performance measures and health status (outcomes), with all levels of government being accountable to the Canadian public.

CHA and our provincial and territorial members are very interested in working with others in the identification and implementation of existing and new accountability mechanisms to ensure their reliability and relevance.

Advancing Health System and Health Services Research

Health system and health services research leads to innovations and improvements in healthcare delivery and health outcomes. Recently, significant progress has been made in advancing health systems and health services research. This momentum must be sustained.

Potential strategic investments that will advance health system and health services research include a focus on:

- Adequate Funding for All Types of Health Research (e.g., biomedical, applied clinical, health services and health systems, and population health research)
- Equity Demonstrated in the Structure and Governance of the Canadian Institutes for Health Research (CIHR)
- Integrated Research Initiatives
- Development, Dissemination and Implementation of Research Results

Health services and health systems research needs to be fostered and advanced in Canada to ensure that government decision makers, managers of the healthcare system, healthcare providers and consumers can engage in evidence-based decision making at the personal, service delivery and system wide levels.

CHA and our member organizations will continue to advocate for, participate in, and benefit from health services and health systems research in Canada.

Contributing to the Productivity of Canadian Society

Our publicly funded healthcare system not only meets the needs of individuals and communities across Canada, it also provides a competitive advantage for Canadians in the global economy. An investment in healthcare is an investment in productivity. However, this investment in healthcare will be constantly challenged by competing demands for debt reduction, tax cuts and spending on social programs. These challenges will need to be considered from the perspective of Canada's productivity and global competitiveness.

Potential strategic investments that will enable the publicly funded health care system to continue contributing to the productivity of Canadian society include a focus on:

- Taxes versus Healthcare Spending
- The Federal Government's "Balanced" Approach

Support from groups other than healthcare advocates is needed to demonstrate that the message "an investment in healthcare is an investment in productivity" is not simply an advocacy position of those with vested interests, but is vital to Canada's productivity and global competitiveness. The business sector is starting to speak out on the need to support a publicly funded, single payer healthcare system in Canada.

CHA and our provincial and territorial members are committed to maintaining and strengthening Canada's publicly funded healthcare system so as to improve the health status of Canadians and contribute to Canada's productivity and global competitiveness.

Providing Sufficient and Long Term Funding

Daily, healthcare facilities and agencies across this country are meeting urgent and continuing care needs while struggling with inadequate resources. They are trying to maintain quality care while living with the consequences of historical cuts in funding for healthcare. Sufficient and long term funding of the system is urgently needed from federal, provincial and territorial governments. However, CHA and our member organizations understand that public resources for our healthcare system are finite. Financial resources for healthcare must be prudently allocated within an innovative and responsive healthcare system.

Potential strategic investments to ensure sufficient and long term funding of Canada's publicly funded healthcare system include a focus on:

- Establishing a CHST Cash Floor of $15 Billion Immediately
- Funding a National Home and Community Care Program
- Ensuring a Growth Factor for the Cash Component of the CHST
- Exploring New Funding Mechanisms
- Monitoring and Evaluating the Extent of Private Sector Financing and Delivery, and Developing National Standards

In addition to these strategic investments by the federal government, similar commitments will be needed by the provincial and territorial governments to ensure that sufficient and long term funding is available for health systems across Canada. While the health needs and priorities of each province and territory may be different, what is the same is the need for sufficient and long term funding to ensure that all Canadians have access to reasonably comparable services where and when they need them.

CHA and our member organizations are committed to using these needed additional resources to create a sustainable, accessible, accountable, integrated and publicly funded system that will meet the current and future needs of Canadians, and to foster a competitive advantage for Canadians in the global economy.

Next Steps

Creating a sustainable healthcare system is not just about money — it is also about leadership. Canadians expect healthcare facilities and agencies, healthcare providers, non-governmental organizations, and all levels of government to work collaboratively to create a sustainable healthcare system that will be there for them and their families.

The Canadian Healthcare Association looks forward to working with others to facilitate public discussion and debate regarding maintaining and improving our healthcare system; identifying potential solutions for addressing the many challenges facing the system; and implementing effective solutions to ensure a sustainable, innovative, integrated, accountable and publicly funded healthcare system.

It is hoped that this discussion paper will be a valuable resource in this public discussion and implementation of effective solutions. A workshop kit is also being developed to help providers, managers, trustees, government decision makers and the general public review CHA's Sustainability Framework and make comments and suggestions for further action. Comments can be directed to the Canadian Healthcare Association or to our provincial and territorial member hospital and health organizations.

Together we can create a sustainable healthcare system that is responsive to the needs of all Canadians in the new millennium.

CHA's Framework for a Sustainable Healthcare System in Canada

DISCUSSION PAPER

CHA AND OUR PROVINCIAL ANND TERRITORIAL MEMBER ORGANIZATIONS

The Canadian Healthcare Association (CHA) is the federation of provincial and territorial hospital and health organizations committed to preserving and strengthening Canada's health system. CHA represents regional health authorities, hospitals, and healthcare facilities and agencies, which employ close to one million healthcare workers, and serve Canadians across the country. These organizations are governed by trustees who act in the public interest.

CHA was founded in 1931 and historically represented hospital associations at the national level. In 1995, our name was changed from the Canadian Hospital Association to the Canadian Healthcare Association to reflect the broadening scope of our provincial and territorial members. Today, through our member organizations, CHA represents a broad continuum of care, including:

- hospitals,
- long-term care facilities,
- home and community care agencies,
- community health services,
- public health,
- mental health,
- addiction services,
- housing services,
- child, youth and family services, and
- professional and licensing bodies.

The Canadian Healthcare Association is the national voice of this health network.

CHA's vision is a publicly funded health system that provides access to a broad range of comparable health services across Canada. CHA's mission is to improve the delivery of health services in Canada through policy development, advocacy and leadership.

CHA'S REASONS FOR DEVELOPING THIS FRAMEWORK

This framework for a sustainable healthcare system in Canada was developed by CHA's Board of Directors as a benchmark to ascertain if new initiatives for maintaining and improving the healthcare system in Canada are working collectively and cooperatively toward a common end — providing Canadians with the appropriate level of care by the appropriate caregiver at the appropriate time in the appropriate place. It is a framework not only for today, but also for the new millennium. It challenges individuals, organizations and governments to proactively engage in the future.

CHA's overall message of sustainability is important for a number of reasons, including to:

- Demonstrate that healthcare facilities and agencies are part of the solution. Healthcare managers and providers are committed to working with others to ensure that the healthcare system is responsive to the needs of Canadians and provides services in appropriate and innovative ways. The answer is not just more government money; health facilities and agencies must be champions and agents of effective change.

- Provide objective and clear reasons why there is still not enough money in the system — including the consequences of not securing adequate and long-term public funding.

- Establish that an investment in healthcare is an investment in productivity, innovation and knowledge development, as well as in the health of Canadians.

- Encourage and facilitate public discussion and debate regarding our healthcare system and the necessary components for its sustainability as an innovative, integrated, accountable and publicly funded system.

CHA's Framework for a Sustainable Healthcare System will be used by CHA and our provincial and territorial member organizations as the basis for a number of policy and advocacy initiatives.

KEY COMPONENTS OF CHA'S SUSTAINABILITY FRAMEWORK

The key components of CHA's framework for a sustainable, publicly funded healthcare system in Canada are:

3. Responding to the Changing Health Needs of Canadians

4. Realizing the Vision of an Innovative and Integrated System

3. Ensuring the Availability of Appropriate Health Human Resources

8. Developing and Implementing Appropriate Accountability Mechanisms

9. Advancing Health System and Health Services Research

10. Contributing to the Productivity of Canadian Society

11. Providing Sufficient and Long Term Funding

CHA's understanding of the prerequisites for effective change, the outstanding issues to be addressed, and potential strategic investments related to each component of the sustainability framework are outlined in the following pages.

1. RESPONDING TO THE CHANGING HEALTH NEEDS OF CANADIANS

1.1 Prerequisites for Effective Change

With our understanding of the determinants of health becoming clearer and the composition of the Canadian population constantly changing, our healthcare system must adapt if it is to be responsive and effective. CHA and our member organizations advocate for a health system that is responsive to the health needs of individuals and communities.

Some prerequisites for effective change related to responding to the changing health needs of Canadians have been identified as follows:

- A better understanding and greater appreciation for the broader determinants of health will require the health sector to work collaboratively with other sectors to meet common needs.
    - *Working with other sectors:* For example, the "National Children's Agenda" was announced May 7, 1999 by the Federal/Provincial/Territorial Council on Social Policy renewal. This initiative has four goals for children: good health, safety and security, success at learning, and social engagement and responsibility. While the health system will have an important role to play in achieving these goals, other sectors will also contribute significantly to meeting the needs of children.
    - *A better understanding of the determinants of health:* For example, in some provinces, housing is considered part of the health sector and regional health authorities are developing innovative strategies for integrating assisted and/or social housing into their broader health system.
- A shift from a focus on the health of individuals to the health of populations will require new ways of assessing health needs and new priorities within and beyond the healthcare sector.

Our current healthcare system is meeting a wide range of health needs. As this system becomes more comprehensive, health needs can be met more wholistically.

1.2 Outstanding Issues to be Addressed Related to Changing Health Needs

There are a number of outstanding issues related to the changing health needs of Canadians that will need to be addressed if a sustainable healthcare system is to be created. These issues include:

- Current and future changes in the demographic profile of Canadians (e.g., overall aging of the population; older, frailer seniors; population growth; fewer people in the workforce; etc.) are leading to changes in:

  - health conditions (more chronic diseases),
  - care settings (home and community care; long term care),
  - service delivery (realignment of hospitals), and
  - the range of services (promotion, prevention, rehabilitation).

- The health needs of specific populations — such as Aboriginal peoples, immigrants and refugees, children, Canadians living in rural, remote and northern areas — require special attention, both in terms of the magnitude of the problems and the fact that the existing healthcare system has not adequately met their needs.

- New technologies (including medical interventions, equipment and devices, pharmaceuticals, and health information systems) are providing improved and different ways to meet the needs of Canadians.

These dramatic shifts in health needs and technologies are requiring significant changes in the delivery and integration of health services.

1.3 Potential Strategic Investments — Responding to Changing Health Needs

The CHA Board of Directors has identified a number of strategic investments, on the part of governments, healthcare managers and the general public, which will enable a sustainable healthcare system in Canada to be responsive to the changing health needs of Canadians. These strategic investments include:

- *Population Health:* Many of CHA's member organizations have embraced the concept of population health and are urging CHA, at the national level, to become more involved in the broader determinants of health, such as housing and environmental issues. The CHA Board of Directors will be considering some of these issues at their upcoming meetings, in terms of potential new policy and advocacy priorities for the national office and/or supporting issues and initiatives at the provincial and territorial levels.

- *Children's Health:* CHA fully supports the need for additional resources to be allocated by the federal, provincial and territorial governments to address children's issues. However, CHA is advocating that governments avoid either/or scenarios and provide leadership by allocating resources that enhance both the healthcare system and the broader social infrastructure. CHA is also encouraging decision makers to focus on the needs of Canadians at all lifestages, from pre-birth to death. CHA and our member organizations are committed to working with other sectors, providers, consumers and governments to address the significant challenges facing Canadian children.

- *Aboriginal Health:* Many of CHA's member organizations are working closely with Aboriginal groups to address the critical issues facing their communities. In consultation with our members and national Aboriginal organizations, CHA is exploring various options for contributing to the overall goal of improving the health and wellbeing of on- and off-reserve, status and non-status First Nations people, Inuit and Metis.

- *Rural, Remote and Northern Health:* Many of CHA's member organizations have identified rural, remote and northern health needs as a priority and are actively engaged in finding solutions. At the national level, CHA has been monitoring the work of Health Canada's Office of Rural Health and is looking forward to participating in initiatives to develop plans for addressing rural, remote and northern health needs through research and specific strategic initiatives.

- *New Technologies:* CHA and our member organizations are advocating for additional government resources at the federal, provincial and territorial level to support the tremendous potential for greater knowledge development within the healthcare sector. This investment will lead to innovative, new technologies that will enable our healthcare system to more effectively and efficiently respond to the changing health needs of Canadians.

CHA and our provincial and territorial members would welcome the opportunity to work with others to ensure that the healthcare system, now and in the future, is responsive to the health needs of Canadians.

2.0 REALIZING THE VISION OF AN INNOVATIVE AND INTEGRATED SYSTEM

2.1 Prerequisites for Effective Change

The health system for the new millenium will look and operate very differently from the health system that evolved in the 20th century. However, core public values must be maintained. CHA's vision is a publicly funded health system that provides access to a broad range of comparable health services across Canada.

Some prerequisites for effective change related to realizing the vision of an innovative and integrated system have been identified as follows:

- There is a window of opportunity now with the signing of the Social Union agreement and the Health Accord for provincial, territorial and federal governments to demonstrate their willingness and ability to work together to realize common visions and develop collaborative solutions for the challenges facing the healthcare system. Canadians expect nothing less.
- Needed home and community care services must be integrated within the publicly funded system to ensure that all Canadians, no matter where they live, have access to comparable, needed services at all ages and stages of health.
- Innovation must be encouraged and fostered in the areas of technology, delivery systems and organizational structures.
- Healthcare managers and providers must:
  - become leaders in incorporating innovations in their day-to-day activities;
  - work collaboratively with all components of the healthcare system to ensure that services coalesce into an integrated system of care; and
  - reach out to and work with other health-determining sectors to ensure that all of the determinants of health are effectively addressed.
- CHA and its members are key players in developing and realizing this vision of an innovative and integrated system. Our focus on sustainability indicates that not only must others do something about the challenges, but we, as healthcare managers and providers (CHA's collective membership), must also take responsibility for needed changes.

A long term, strategic vision is needed of a sustainable, innovative, integrated and publicly funded healthcare system that is responsive to the changing needs of Canadians.

2.2 Outstanding Issues to be Addressed Related to Realizing the Vision of an Innovative and Integrated System

There are a number of outstanding issues that will need to be addressed in order to realize the vision of an innovative, integrated and sustainable healthcare system in Canada. These issues include:

- With finite public resources available to fund the healthcare system, there is growing urgency to delineate the boundaries of our publicly funded system. The Canada Health Act is under increasing scrutiny. Some see it as the albatross that is preventing innovation within the system. Others see it as the foundation of our publicly funded system. Important questions need to be addressed regarding the interpretation of the Act's principles and the scope of the system that is covered by the Act. Specifically, the following issues need to be publicly debated and resolved:

  - what "core" services are currently covered under medicare? and
  - what range of services should be covered through our publicly funded system?

  These questions address the broader issue of trying to achieve better alignment between public and political expectations for health services and the system's capacity to deliver. System capacity is in turn influenced by funding.

- As we enter a new millenium, it is time for new ventures and visions — we need to build on the past and embrace the future. However, as many have noted, Tommy Douglas' vision was not won easily or implemented quickly. We must be clear as to what our common goals are, realistic in terms of the timeframes needed to realize these goals, and ever vigilant to ensure that the core of Tommy Douglas' vision stays alive. Federal, provincial and territorial leadership is needed to articulate a vision for healthcare in Canada. This vision needs to be supported by common goals and objectives that can provide direction in the reshaping of a sustainable, publicly funded system.

- Currently, due to the significant funding cutbacks and organizational change, many healthcare facilities and agencies are operating under crisis management. To encourage innovative and strategic actions to be taken, long range visions of organizational and delivery structures are needed at the federal, provincial and territorial levels. Sufficient and long-term funding commitments are also needed to realize the vision of an innovative and integrated healthcare system.

- The health system is not yet finished the process of "reforming" or "renewing". Within the Canadian health system, significant questions are being raised regarding the delivery of services. Issues include primary care reform, physician remuneration, and regional funding formulas.

Many different issues will need to be addressed for us to collectively realize the vision of an innovative and integrated healthcare system.

2.3 Potential Strategic Investments — Realizing an Innovative and Integrated System

The CHA Board of Directors has identified a number of strategic investments, on the part of governments, healthcare managers and the general public, which will enable the vision of a sustainable healthcare system to be realized. These strategic investments include:

- *Public Understanding and Debate*: To realize the vision of an innovative and integrated system that is sustainable, we need to start with a common understanding of what currently exists.

    - CHA, in consultation with our provincial and territorial members, is developing a description of how healthcare is currently organized and governed in each province and territory.

    - CHA has already developed the Policy Brief entitled *Funding Canada's Healthcare System* that describes funding issues for the acute care system. We have now begun the process of describing the funding and delivery issues for home, community and long term care across the country.

    - CHA is also exploring the discrepancies in what is currently insured and not insured within the publicly funded health insurance of each province and territory. This activity will require the collaboration of other researchers and external funds to be completed.

    This information regarding current organizational structures, funding issues, and existing coverage of "medically necessary" services will provide a basis for informed public debate regarding current and future parameters of a sustainable, publicly funded system in Canada. This common understanding will facilitate the allocation of scarce public resources to needed healthcare services.

- *The Canada Health Act:* CHA does not support the call by some organizations to open the Canada Health Act. Rather CHA advocates for the existing provisions of the Act to be interpreted and acted upon so as to ensure access to comparable, needed services for all Canadians within a publicly funded system. In terms of expanding the healthcare system to encompass home and community care, CHA is advocating for additional federal funding and provincial and territorial commitments to new principles regarding access by Canadians to reasonably comparable home, community and long term care services. These principles will need to be developed by the federal government in consultation with the provinces and territories. (See section 7.0.) Overtime, it is envisioned that the legislation or regulations governing these principles and the Canada Health Act may be merged to enable a full integration of services within the health system.

- *Publicly Funded Home and Community Care:* Healthcare funding is needed not only to ensure accessibility to health services currently covered by medicare, but also to accommodate the transitions inherent in healthcare restructuring, and to support the broader continuum of care. Healthcare funding and reform must include investment in and augmentation of all parts of the continuum of care, to achieve our vision of a sustainable, integrated, and client-centred continuum of care. As outlined in our recent briefs to the Standing Committee on Finance, CHA is advocating for additional cash transfers from the federal government to provincial and territorial governments to expand the existing system so as to ensure the sustainability of a broad continuum of needed services. This is in addition to the increased level of federal funding required for the Canada Health and Social Transfer (CHST) cash floor to stabilize the existing system. (See section 7.0 for more details.)

- *Strategic Directions, Goals and Objectives:* Many provinces already have broad healthcare goals and objectives. It is important that that all Canadians, no matter where they live, have access to comparable services across a broad continuum of care. Therefore, CHA is advocating that federal, provincial and territorial governments — in consultation with non-governmental health groups, managers, providers, researchers and consumers — develop common strategic directions, goals and objectives that could be modified in each province and territory to reflect the specific health needs and delivery systems of each jurisdiction.

- *Long Range Plans for the Organization and Delivery of Healthcare*: CHA is advocating that governments, in consultation with non-governmental health organizations, managers, providers and consumers, develop long range plans for the organizational structure and delivery of healthcare services. This will curb the decade long necessity of management by crisis and will enable innovative and integrated plans to be developed and implemented.

- *Sufficient and Long Term Funding*: A sustainable system that is innovative and integrated requires sufficient and predictable funding over the long term. Each fall CHA outlines its funding positions in a brief to the federal Standing Committee on Finance. Please refer to this year's brief for more details regarding CHA's specific funding priorities. This issue is also discussed in detail in section 7.0.

- *Alternative Delivery Models*: Some provinces have begun the process of primary care reform. And, many provinces and territories are examining physician remuneration issues, with some funding pilot studies of alternative payment mechanisms. At this time, CHA is watching these developments to determine what actions would be appropriate at the national level.

CHA and our provincial and territorial members are committed to being integral partners in realizing the vision of a sustainable healthcare system that is innovative and integrated.

3.0 ENSURING THE AVAILABILITY OF APPROPRIATE HEALTH HUMAN RESOURCES

3.1 *Prerequisites for Effective Change*

A key component of ensuring a sustainable healthcare system is the availability of health human resources. CHA's members across the country are experiencing first hand the challenges associated with health human resources. Healthcare facilities and agencies are the major employers of healthcare workers and many of CHA's provincial and territorial members are the employer representative in labour negotiations. CHA's perspective in terms of health human resources issues, however, is not limited to the "employer" perspective: we are advocating from a "systems" perspective and from a "public interest" perspective to ensure that a responsive healthcare system can be sustained.

Some prerequisites for effective change related to health human resources have been identified as follows:

- Ensuring the availability of "appropriate" health human resources requires an adequate number of a broad range of healthcare providers who are appropriately educated and trained to perform required activities to meet the current and future health needs of Canadians.
- Healthcare providers need to be recognized as an integral component of the healthcare system.
- Short term and long term solutions are needed.
- National, as well as provincial and territorial initiatives are required to identify options and implement solutions. These solutions need to be identified and developed collaboratively with providers, employers, unions, consumers, and governments. No one group has the solution.
- Initiatives must focus not only on recruiting and retaining new providers but must also address the care and nurturing of existing providers.
- A futuristic health human resources plan is needed, one which considers new delivery models and health needs and does not consider individual provider groups in isolation.
- Health human resources planning must facilitate the development of an integrated healthcare system.

Many of these prerequisites have been recognized and are integral to the health human resources initiatives currently underway.

3.2 *Outstanding Issues to be Addressed Related to Health Human Resources*

There are a number of issues that will need to be addressed in to ensure the availability of appropriate health human resources for a sustainable healthcare system in Canada. Many of these issues are highlighted below under three categories: the health system, the provider and the employer perspectives. Many of the issues could appear in each category. Which ever way they are categorized, all of these issues need to be addressed to ensure that Canadians have access to needed services across a broad continuum of care.

- Major issues to be addressed from a health system perspective include:
  - demographic shifts which will see a significant proportion of current providers retiring over the next 15 years, with fewer new graduates replacing them;
  - emergence of new licensed and unlicensed providers;
  - roles and needs of informal caregivers;
  - changing technologies and practices in the workplace requiring retraining;
  - education and training of new and existing healthcare providers;
  - new remuneration mechanisms (e.g., fee-for-service vs. salaries or capitation);
  - lack of coverage within the publicly funded health system (e.g., physiotherapists, occupational therapists, and home care workers in some provinces and territories);and
  - paucity of data and information for effective health human resources planning.
- Major issues to be addressed from a provider perspective include:
  - current working conditions (including casualization);
  - shifting roles and responsibilities of existing providers; and
  - salary levels.
- Major issues to be addressed from an employer perspective include:
  - demographic shifts in the populations requiring services, for example more seniors requiring different numbers and types of providers;

- availability of adequate numbers of appropriately trained healthcare providers (including issues related to potential "brain drains" and adequate numbers of training positions available);

- poaching of newly graduated and existing healthcare providers from one province or territory to another;

- distribution of appropriately trained healthcare providers, including in rural, remote, northern and urban areas; and

- retaining new and existing healthcare providers (including addressing many of the provider issues listed above).

All of these perspectives will need to be considered when clarifying the issues and developing effective strategies for addressing the complex and interwoven issues.

3.3 Potential Strategic Investments — Health Human Resources

The CHA Board of Directors has identified a number of strategic investments, on the part of governments, healthcare managers and the general public, which will be needed to ensure the availability of appropriate health human resources. These strategic investments include:

- *A Health Human Resources Plan for Nurses*: The CHA Board of Directors has identified nursing issues as one of two top health human resources priorities. CHA is encouraged by the interest and financial support indicated by Health Canada and Human Resources Development Canada to undertake a Nursing Sector study. The results of this sector study will provide a long term blueprint for action for nursing across Canada. CHA and our member organizations have been and will be taking an active role throughout this initiative. Provincial and territorial government participation in and support of the process and findings of this Nursing sector study will be critical.

- *A Health Human Resources Plan for Physicians:* The CHA Board of Directors has identified physician issues as the other top health human resources priority. CHA is currently reviewing the national and federal/provincial/territorial initiatives that are underway. CHA is advocating for active participation in these initiatives as the national representative of the employing facilities and agencies affected by many of the physician-related health human resources issues.

- *A Health Human Resources Plan for Home Care Workers:* CHA is hopeful that Health Canada and Human Resources Development Canada will financially support the development of a Home Care Worker sector study. CHA has participated in some initial meetings and has expressed an interest in fully participating in any future initiative. Again, provincial and territorial government participation in and support of the process and findings of a Home Care Workers sector study will be critical to its long-term success.

- *Shorter Term Initiatives:* The initiatives described above focus on developing solutions for the long term. Some short term solutions are also needed. These could include:
    - Involvement of federal, provincial and territorial governments in supporting short-term solutions such as establishing a national nursing council and overcoming barriers to financial support to facilitate continuing education and retraining.
    - Sharing of information regarding current initiatives in each province and territory to avoid duplication of effort and identify potential areas for collaboration. This information needs to be shared between governments and with healthcare managers and providers. CHA is currently completing descriptions of resources and initiatives at the national, provincial and territorial levels related to nurses and physicians. Information related to a number of other provider groups (including physiotherapists, lab technicians and others) is also being collected at a summary level.

    These short-term initiatives, if shared and supported across the country, could provide some immediate relief to the critical issues of health human resources.

- *Federal, Provincial and Territorial Funding:* Part of the solution to the health human resources challenges will be sufficient and long term funding for healthcare to address current issues regarding working conditions, pay levels and emigration. Details of what is meant by "sufficient and long term funding" can be found in CHA's brief to the Standing Committee on Finance that is submitted each fall. An overview of CHA's current positions is provided in section 7.0.

CHA and our member organizations look forward to working with other partners to identify the key issues, develop options, and implement feasible solutions to the many health human resources issues which are testing the sustainability of our healthcare system.

4.0 DEVELOPING AND IMPLEMENTING APPROPRIATE ACCOUNTABILITY MECHANISMS

4.1 Prerequisites for Effective Change

CHA's provincial and territorial member organizations are working hard to maintain quality care and improve accountability to governments and Canadians within the context of cost containment.

Some prerequisites for developing and implementing appropriate accountability mechanisms have been identified as follows:

- Many accountability relationships must be honoured. These relationships, with responsibilities flowing in both directions, include: government-to-government, governments-to-providers, governments-to-Canadians, and providers-to-consumers.
- CHA's understanding of accountability is that the focus is not on the provincial and territorial governments being accountable to the federal government. Rather, the primary focus of accountability should be that all levels of government (federal, provincial, territorial, regional and municipal) are accountable to the Canadian public.
- The focus of accountability should be on performance measures and health status (outcomes), not tracking dollars. And, in terms of performance measures, the focus should be on identifying ways to improve not punish components of the health system.
- Accountability mechanisms need to be objective and transparent.
- Health system indicators must reflect systems, processes and outcomes.
- For accountability mechanisms to be effective, reliable data are needed. Therefore, integrated health information systems are essential components of effective accountability mechanisms.
- Information systems at the local, regional, provincial/territorial and national levels must encompass the broad continuum of care within the health system.
- A long term vision is needed to ensure that we are not limited to existing data sets for measuring and understanding the performance of the healthcare system.

Healthcare facilities and agencies are committed to providing clear, objective information regarding their effectiveness and efficiency in providing services and their impact on the health status of Canadians.

4.2 Outstanding Issues to be Addressed Related to Accountability

There are a number of outstanding issues that will need to be addressed to enable the development and implementation of appropriate accountability mechanisms to support a sustainable healthcare system in Canada. These issues include:

- Clarity is required in terms of the definition and purpose of accountability; the availability of valid and tested accountability mechanisms; and the understanding of who is accountable for what, to whom, how and when?
- Basic infrastructures are still needed to fully support accountability initiatives at the local, regional, provincial, territorial, and national levels. A national health information infrastructure must be developed and supported.
- Privacy and confidentiality issues will need to be addressed, balancing the rights of the individual with the needs of communities and society.

While many have embraced the concept of and need for greater accountability within the healthcare system, a number of issues will need to be addressed to ensure that accountability initiatives improve, not paralyze the system.

4.3 Potential Strategic Investments — Accountability Mechanisms

The CHA Board of Directors has identified a number of strategic investments, on the part of governments, healthcare managers and the general public, which will be needed to develop and implement appropriate accountability mechanisms. These strategic investments include:

- *Governments, Researchers and Healthcare Groups Working Together:* CHA is advocating that federal, provincial and territorial governments and agencies (including the Canadian Institute for Health Information) work more closely with healthcare groups (such as CHA and our member organizations), provider groups, researchers, and consumers to develop and implement meaningful and realistic accountability mechanisms and performance measures.
    - The ultimate success of any accountability mechanism will be the successful implementation by individual facilities and agencies. Their input in determining the scope of accountability, developing potential mechanisms and choosing the preferred option, is critical if the outcomes of the accountability mechanisms are to be meaningful.
    - CHA is aware of at least one federal initiative gathering information on accountability mechanisms across the country. CHA and our members have provided information to the researchers. The next stage of this research should be to integrally involve representatives of healthcare facilities and agencies from across the country in dynamic discussions

regarding the relevancy and accuracy of the various accountability mechanisms being considered.

- *Support for National Health Infostructure Initiatives:* CHA and its member organizations support the work of the Health Infoway report by the Advisory Committee on Health Infostructure and the CIHI Roadmap report. We will continue to monitor and participate in indicator initiatives and related health infostructure activities of the Canadian Institute for Health Information, the Canadian Council of Health Services Accreditation and Health Canada. CHA and our provincial and territorial members are committed to being integral partners in realizing the vision and recommendations provided by these important initiatives.

- *Federal Funding for Health Infostructures:* CHA commends the federal government for supporting the health information systems initiatives announced in the February 1999 federal budget, including building a national health surveillance network, establishing a Canada Health Network, supporting innovative Telehealth initiatives, and enhancing the work of the Canadian Institute for Health Information (CIHI). Provincial and territorial health information systems also need to be financially supported to be able to develop region-specific data sources and to be integrated with other systems in a pan-Canadian health infostructure.

- *Sharing of Information:* CHA is developing a list of key issues, resources and initiatives regarding accountability at the national, provincial and territorial levels. Part of this work is being augmented by a national study on accountability being funded through Health Canada's National Health and Research Development Program (NHRDP). The purpose of this CHA activity is to share information, avoid duplication of efforts and identify potential areas for collaboration.

- *Privacy and Confidentiality:* CHA has identified a number of concerns regarding the proposed federal legislation Bill C-6 (previously known as Bill C-54). We are working with other national organizations with similar concerns to review the impact of this bill on the ability of the healthcare system to collect information needed to support population health initiatives and evidence-based decision making. We understand that some of the provinces and territories share our concerns. In addition to federal legislation, provincial and territorial legislation is also required; some jurisdictions have completed this process and others have just begun. CHA and our member organizations would like to be integrally involved in the development and implementation of these important pieces of federal, provincial and territorial legislation which significantly impact on the ability of the healthcare system to be effective, efficient and accountable.

CHA and our provincial and territorial members are very interested in working with others in the identification and implementation of existing and new accountability mechanisms to ensure their reliability and relevance.

5.0 ADVANCING HEALTH SYSTEM AND HEALTH SERVICES RESEARCH

5.1 Prerequisites for Effective Change

Health system and health services research leads to innovations and improvements in healthcare delivery and health outcomes. This research is vital to ensuring the development of a sustainable, innovative, integrated, publicly funded system.

Some prerequisites for advancing health system and health services research have been identified as follows:

- Health services and health systems research needs to be fostered and advanced in Canada to ensure that government decision makers, managers of the healthcare system, healthcare providers and consumers can engage in evidence-based decision making at the personal, service delivery and system wide level.
- The value of health services and health systems research must be proven to healthcare managers and providers in terms of the improvements it can make in the health status of Canadians, the increased efficiency and effectiveness it can bring to the Canadian healthcare system, and the untapped global market available for this unique research on a publicly funded healthcare system.
- Mechanisms are needed to ensure that decision makers, managers, providers and consumers know how to access new research findings, assess its reliability, and translate the research into action. This will require a number of different approaches, including training "knowledge brokers" to work in healthcare agencies to facilitate the transfer of knowledge from researchers to managers and providers; continuing education opportunities for those who need to become more familiar with research and how to use it; and new technologies and communication vehicles that can facilitate the transfer of research in ways that are easy to access and easy to transfer to action.

Recently, significant progress has been made in advancing health systems and health services research. This momentum must be sustained.

5.2 Outstanding Issues to be Addressed Related to Advancing Health Research

There are a number of outstanding issues that will need to be addressed to advance health system and health service research so that it can support a sustainable healthcare system in Canada. These issues include:

- Traditionally, the majority of health research dollars have supported biomedical and clinical research. More research is needed in the area of health systems research and health services research. Such research examines how systems (e.g., organizational, funding and government systems) can be changed to be more effective and efficient, and how the delivery of health services can be improved to better meet the needs of consumers and improve health outcomes.

- There are a multiplicity of government and non-governmental research funding bodies at the national, provincial and territorial levels. However there is currently little coordination of research priorities, application processes, or peer-review processes.
- While some good health system and health services research is currently being conducted there are still major issues related to the dissemination of this information. For example, in some cases only traditional methods of dissemination are used, such as publications in peer review journals or presentations to academic conferences. These methods do not get the research findings to those that need them, including policy makers, program managers, provider and consumers. More time, attention and resources are needed to develop effective dissemination strategies.
- It has been known for some time that if research findings are to be meaningful and change behaviour, then the people affected (e.g., providers, managers and decision makers) need to be actively involved in designing and conducting the research. Research grants that encourage or insist on this partnership are beginning to emerge, but more work is needed to encourage "participatory" or "action" research.

These issues affect all aspects of the research, from protocol design to the implementation of findings. The greatest challenge, however, is having health systems and health services research recognized within the broader health research community as a valuable and legitimate field of research.

5.3 Potential Strategic Investments — Advancing Health Research

The CHA Board of Directors has identified a number of strategic investments, on the part of governments, healthcare managers and the general public, which will be needed to advance health system and health services research. These strategic investments include:

- *Adequate Funding for All Types of Health Research:* CHA commends the federal government for the leadership it demonstrated in the 1999 budget in recognizing the need for and support of a broad range of health research, including: biomedical, applied clinical, health services and health systems, and population health research. This was evidenced through the development of the Canadian Institutes for Health Research (CIHR). Provincial and territorial funding for health system and health services research is also recognized. Financial support from all levels of government will need to be significant and ongoing if a base of Canadian expertise is to develop and flourish.

- *Equity Demonstrated in the Structure and Governance of the CIHR:* CHA fully supports the development of the Canadian Institutes for Health Research (CIHR), but we are concerned that this new body may not be appropriately structured or governed to equitably support the many facets of health research in Canada. It is feared that within the CIHR, the biomedical and applied clinical research communities will continue to have the most decision making power and financial resources. The development of the CIHR is being monitored by CHA through our active involvement in the Network for the Advancement of Health Services Research (NAHSR), a coalition of organizations interested in health system and health services research. Collectively, we believe in the need to strengthen health system and health services research in Canada and we will be looking to the CIHR to facilitate this advancement.

- *Integrating Research Initiatives:* The CIHR will go a long way to integrating health systems and health services research across the country, however, there are a number of provincial and territorial research bodies, and perhaps some national bodies, that will not be part of this new structure. Mechanisms will need to be developed for ensuring greater communication and consultation among the research communities in Canada. Federal, provincial and territorial resources will be needed to support this integration.

- *Development, Dissemination and Implementation of Research Results:* More and more, CHA and our member organizations are being invited to participate in research projects. Often, we need to work closely with researchers to ensure that we are actively involved and not merely consulted occasionally in the development of the research. We have also been asked to comment on dissemination strategies, for example for research emanating from the Health Transition Fund and from individual research projects. CHA and our member organizations welcome opportunities to advance the development and findings of health system and health services research.

CHA and our member organizations will continue to advocate for, participate in, and benefit from health services and health systems research in Canada.

6.0 Contributing to the Productivity of Canadian Society

6.1 Prerequisites for Effective Change

Our publicly funded healthcare system not only meets the needs of individuals and communities across Canada, it also provides a competitive advantage for Canadians in the global economy. An investment in healthcare is an investment in productivity.

Some prerequisites for ensuring that a sustainable healthcare system continues to contribute to the productivity of Canadian society include:

- A clear understanding (including agreement on definitions and performance measures) is needed of what is meant by the term productivity. A common misperception by the general public is that "productivity" means working harder for less money. This public perception needs to be addressed and Canadian workers need to be reassured that they are not being asked to continue to do more with less.
- Governments and the Canadian public are beginning to understand the significant contribution our publicly funded healthcare system makes to the productivity of Canadian society. This understanding is needed for governments and the public to continue to support a sustainable, publicly funded healthcare system in Canada.
- Canada's publicly funded health system adds to the productivity of our society by contributing to:
    - the Canadian economy,
    - the standard and quality of life enjoyed by Canadians,
    - employment rates,
    - business decisions to locate international companies in Canada;
    - economic development (through health research and innovations),
    - a healthy population, and
    - a healthy workforce.
- As the Prime Minster noted in the *Prime Minister's Update: A Review of National Issues* (Summer, 1999): "Nothing more eloquently testifies to the depth of the bedrock Canadian values of sharing, compassion and mutual responsibility than our collective decision to create Medicare — our cherished, universal, publicly funded healthcare system . . . . Medicare is essential to our unmatched quality of life."

- Support from groups other than healthcare advocates is needed to demonstrate that the message "an investment in healthcare is an investment in productivity" is not simply an advocacy position of those with vested interests, but is vital to Canada's productivity and global competitiveness. The business sector is starting to speak out on the need to support a publicly funded, single payer healthcare system in Canada (at the same time that there are growing demands for significant tax cuts and spending on new social programs):

    - As Charles Baillie, Chair and CEO of the TD Bank, stated in a speech on April 15, 1999 to the Vancouver Board of Trade: "The fact is, moving away from a single payer publicly funded system might cost the government less. But it would cost the country more. It would cost every business, large and small more if they had to pay for benefits themselves. It would, in a very real sense, constitute a de facto increase in taxation — for employers or employees or both."

    - The Conference Board of Canada, with more than six hundred member organizations from business, government and other sectors, also strongly supports Canada's publicly funded healthcare system because it is a competitive advantage.

- As noted in a Health Action Lobby (HEAL) presentation to the federal Standing Committee on Finance Roundtable on Economic Productivity (May 1999), "Canadians are our most valuable resource to maintain a healthy economy. As individuals, they in turn must be healthy, developed and supported to ensure the positive link between health and productivity." Yet, a recent report by Duxbury, Higgins and Johnson commissioned by Health Canada clearly shows that the annual costs to employers ($2.7 billion) and the health care system ($425 million) of highly stressed workers trying to balance work and life.

The full value of our publicly funded healthcare system must continued to be conveyed by many different groups to federal, provincial and territorial governments.

6.2 Outstanding Issues Regarding the Productivity of Canadian Society

An issue dominating the productivity agenda these days is tax cuts. Some issues related to the "tax cut versus healthcare spending" debate are outlined below:

- Many recognize that both healthcare spending and tax cuts can lead to improved productivity in Canada. In a recent *TD Report on Canadian Government Finances* (TD Bank, August 1999), a both/and approach is suggested in terms of spending on tax cuts and healthcare: "Although the federal and provincial governments should focus on narrowing the gap in the overall tax burden, that is not and should not be their only concern. There is a trade-off between cutting taxes and enhancing social programs. Canadians have made it clear that they value the country's social programs — especially the universality, high quality of care, and low private cost of Canada's health-care system. To maintain and enhance the health-care system in the future will require additional funding."

- Many health organizations, including the CHA are not opposed to tax cuts, but the benefits to individuals of tax cuts versus increased personal/private investment in healthcare must be examined. And, since inequities in income is a powerful determinant of health, care must be taken to ensure that tax cuts narrow, not widen, income inequities in Canadian society.

Hard choices will need to be made regarding competing demands. Further public discussion and debate will be needed to clarify these issues.

6.3 Potential Strategic Investments — Contributing to the Productivity of Canadian Society

The CHA Board of Directors has identified sufficient and long term funding as a key component of a sustainable, publicly funded healthcare system (see section 7.0 below). This needed investment in healthcare will be constantly challenged by competing demands for debt reduction, tax cuts and spending on social programs. These challenges will need to be considered from the perspective of Canada's productivity and global competitiveness. From this perspective, the following strategic investments in healthcare need to be considered:

- *Taxes versus healthcare spending:* Federal, provincial and territorial governments need to consider the relationship of healthcare spending and increased Canadian productivity before determining the level of tax cuts for various income levels.

- *The Federal Government's "Balanced" Approach*: In response to competing demands, the federal government has referred to its policy of spending any budget surpluses in a "balanced" way: 50% on tax cuts and debt reduction and 50% on social programs. The relationships between the choices in this "balanced" approach must be recognized and built upon. For example, the tax cuts versus health spending is a false dichotomy if the focus is on productivity. Both can lead to greater productivity. A dynamic equilibrium is needed to enable a both/and (rather than an either/or) approach to allocating scarce resources.

CHA and our provincial and territorial members are committed to maintaining and strengthening Canada's publicly funded healthcare system so as to improve the health status of Canadians and contribute to Canada's productivity and global competitiveness.

7.0 Providing Sufficient and Long Term Funding

7.1 Prerequisites for Effective Change

CHA is a strong advocate for a publicly funded healthcare system that is responsive to the health needs of Canadians. This requires sufficient levels of long term funding for health from the federal, provincial and territorial governments. However, CHA and our member organizations understand that public resources for our healthcare system are finite.

CHA's understanding of funding issues and potential strategic investments are discussed in more detail in the funding briefs CHA submits each year to the federal Standing Committee on Finance. These briefs can be found on the CHA web site at www@canadian-healthcare.org or can be obtained through CHA's Policy Development department. A CHA Policy Brief entitled *Funding Canada's Healthcare System* also provides a primer to healthcare funding issues and can be ordered through the CHA Press.

Some prerequisites for ensuring that a sustainable healthcare system is sufficiently funded over the long term include:

- Cooperation and collaboration between provincial, territorial and federal governments are essential. With the signing of the Social Union agreement and the Health Accord there is a foundation for developing collaborative solutions for the healthcare challenges facing us all.
    - The Social Union agreement provides notification processes and time frames for negotiations between the federal government and the provinces and territories. The focus is on mobility (not just portability) across a broad continuum of care, beyond access to acute care. For new federal programs, buy-in from six provinces (not necessarily 50% of the population) is the basis for agreement. The provinces and territories can access any new federal funds as long as they are meeting the objectives of the "new' program, perhaps through services they are already providing. Quebec can participate in this, even though it did not sign the agreement.
    - In the Health Accord , which consists of two letters: one from the premiers to the PM and one from the Prime Minister, all of the provinces and territories (including Quebec) reaffirmed the five principles of the Canada Health Act.
- As the healthcare system continues to adapt to change, it is essential that the devolution of resources away from acute care services not imperil access to needed healthcare services provided by hospitals. Healthcare funding and reform must include investment in and augmentation of all parts of the continuum of care, to realize our vision of a sustainable, accessible, integrated, client-centred continuum of care.

- The focus of provincial and territorial governments is on the needs and priorities of the electorates in their provinces and territories. It is only the federal government that must focus on the larger, national perspective. Through cash contributions, the federal government maintains it moral authority to ensure a *national* healthcare system. Therefore, the federal government must continue to provide significant cash contributions to the provinces and territories for healthcare.

- Funding decisions must be based on objective information. The prevailing theory in some quarters is that healthcare spending is out of control. This fallacy must be countered with reliable, objective information from credible sources. For example, the Canadian Institute for Health Information (CIHI) has reported that in terms of percentage GDP, total healthcare expenditures (from public and private sources) have steadily declined from 10.0 percent in 1992 to 9.2 percent in 1996. And, in terms of total health expenditures per capita, the annual percentage growth was significantly less than one percent from 1994 to 1996, thus not keeping up with economic growth, an aging population or other demands on the healthcare system.

- The Canadian healthcare system must remain publicly funded; the passive privatization of our healthcare system must be stopped. The unplanned shift to privatization reduces governments' ability to maintain national standards for the quality of care delivered and weakens their ability to direct how healthcare funds are spent. This passive and unplanned approach threatens the principles of Canada's publicly funded system.

- Money alone will not solve all of the challenges facing the healthcare system. Healthcare facilities and agencies are committed to being champions and agents of change, provided that this change effectively and efficiently ensures access to needed services and improves health outcomes.

- Goodwill, collaboration and common visions will also not be enough to achieve a sustainable healthcare system for the new millenium. Adequate and predictable federal cash transfers are essential to ensuring sustainability, accessibility, integration and accountability within the Canadian healthcare system.

- If sufficient and long term funding is not provided immediately, the public's confidence in our healthcare system will be sufficiently eroded to compromise the likelihood of a sustainable, publicly funded system in the future. Canadians will demand a two-tiered health system because the current, inadequately funded system is not meeting their needs. There is still time, but not much time, to address these substantive funding issues and reaffirm Canadians belief in their much cherished healthcare system.

- It is important to remember that there is no separate, special source of money for the private sector — the source is individual Canadians (also known as the customer). Likewise, the source for the public sector, namely, federal, provincial, territorial and municipal governments, is the same — individual Canadians (also known as the taxpayer).

- The federal cash contribution must be significant and must be provided through a flexible mechanism that enables provinces and territories to spend the money on priorities within each of their healthcare systems. Additional federal funds that are targeted to specific programs, without an increase in the federal cash contribution to the overall health system (through the CHST cash floor), will not allow for this needed flexibility. And, targeted funding for specific initiatives is easier to remove at a later date than an ongoing commitment to a cash floor.
- It must be recognized that there is a finite number of public resources for healthcare. CHA and our members are committed to working with the federal, provincial and territorial governments to ensure that the financial resources for healthcare are prudently allocated within an innovative and responsive healthcare system.

Long-term sustainability across a broad range of services — hospitals, home care, community care, long term care, and community health services — is urgently needed. Without a significant and long term investment in healthcare system, facilities and agencies will continue to operate through crisis management. In an atmosphere of crisis, it is difficult to develop a healthcare system for the 21st century.

7.2 Outstanding Issues to be Addressed Related to Funding

There are a number of outstanding issues that will need to be addressed in ensure sufficient and long term funding to support a sustainable healthcare system in Canada. These issues include:

- Daily, healthcare facilities and agencies across this country are meeting urgent and continuing care needs while struggling with inadequate resources. They are trying to maintain quality care while living with the consequences of historical cuts in funding for healthcare. Sufficient and long term funding of the system is urgently needed, now.
- Support for the *existing system* is needed. For example, at the federal level, $2.5 billion was cut from health transfers three years ago, yet, based on announcements in the February 1999 budget, it will take another three years to simply get back to the federal funding level we once had. In these intervening years there has been a growing Canadian population, an aging society, changes in health needs, postponements in needed capital expenditures, restructuring of the health system, and innovations in technology — all requiring additional resources. Without a federal commitment to adequate and predictable funding, it is difficult to meet the current health needs of Canadians or to plan innovative changes to meet future needs.

◆ Yet, many would point to the February 1999 federal budget (also known as the "health budget") and say that healthcare has had its turn. However, those working in health and those needing health services know that the healthcare funding announced in that budget was a step in the right direction, but was not enough. Not enough to meet the current health needs of Canadians or to create a sustainable healthcare system for the future. During the 1999 Budget Speech, the Honourable Paul Martin recognized that the funds allocated to healthcare were not enough when he stated: "As our financial flexibility increases in the years ahead, healthcare will continue to be very much one of the key priorities for future action."

The money allocated to the Canada Health and Social Transfer (CHST) for healthcare in the February 1999 budget seemed impressive — $11.5 billion over five years. However, CHA's provincial and territorial members have told us that these funds will address only some of the most critical problems in our publicly funded healthcare system. It will not address systemic and ongoing problems such as:

- deficit financing by regional health authorities, hospitals, and healthcare facilities and agencies to meet their care obligations, even though deficits are prohibited by law;
- critical levels of frustration among health providers;
- restoring the confidence of Canadians in the healthcare system and their entitlement to publicly-funded, comparable services across the country;
- needed upgrades in health information systems, diagnostic and treatment devices, and pharmaceuticals to meet current and future health needs;
- infrastructure demands such as Year 2000 challenges and anticipated changes to the blood system as recommended in the Krever Commission;
- capital expenditures to maintain physical plants and integrate regional programs;
- increased private sector financing within our healthcare system; and
- disparities (between and within provinces/territories) in what is covered under health insurance plans, for example, "core" medical services that are de-insured or simply not available; co-payments being introduced for acute care services; and shifting services from the acute to community care sector where fewer services are publicly insured.

◆ A sustainable, accessible, accountable and integrated healthcare system for the new millennium cannot be built on a crumbling foundation.

- A greater investment in Canada's publicly funded healthcare system is also required to ensure Canadians have *access to a broad range of needed healthcare services*. Provinces and territories are already investing in this broader continuum of care, however, the availability of needed home, community and long term care services varies across the country, and accessibility is not guaranteed. While the home and community care system will continue to look different in different parts of Canada, there needs to be provincial and territorial adherence to national principles that will ensure that home and community services are available to Canadians when they need them. When federal funding is provided to support the broader continuum of care, the different degrees to which the continuum already exists within the publicly funded system will need to be recognized and provinces and territories must have some flexibility in how the money is allocated within their healthcare systems.

- To ensure *long-term sustainability* a growth factor (or escalator) is needed. This growth factor should be applied to the cash portion of the CHST, perhaps as a compounded three-year moving average of GDP, or it could be tied to the growth in the federal personal income tax revenues. This growth factor (or escalator) will enable the healthcare system to meet new and growing demands and will ensure that the value of the cash portion of CHST is maintained.

- The Canada Health and Social Transfer (CHST) is the current mechanism used by the federal government to transfer tax points and cash to the provinces and territories for health, education and social services. Many are questioning the appropriateness and effectiveness of this transfer mechanism. The question now is: "What is the most appropriate and effective federal funding mechanism(s)?" Options that could be explored include a health-specific transfer, new legislation or regulations to cover the broader continuum of care, and/or allocations based on population-based needs to replace or augment the current per capita formula.

- There has been a gradual shift in Canada's ratio of public to private financing. Two decades ago, private spending represented about 25% of healthcare expenditures, versus 75% for public spending. For 1998, the Canadian Institute for Health Information (CIHI) forecasts private spending at 30.3% and public sector spending at 69.7%. Within a privately funded system, health coverage is based on individual rather than societal risk, and on the ability to pay rather than need. Other issues associated with privatization of the healthcare system include: the Canadian competitive advantage being compromised, distortions in the allocation of resources, the quality of care provided, the lack of public accountability, and private financing versus private delivery of healthcare.

All of these issues — related to adequately supporting our existing system, providing additional public funds to enable access to a broader range of needed services, and ensuring long term stability (through a growth factor and by addressing passive privatization) — must be addressed to ensure a sustainable, publicly funded healthcare system.

7.2 Potential Strategic Investments — Sufficient and Long Term Funding

The CHA Board of Directors has identified a number of strategic investments, on the part of the federal government to ensure sufficient and long term funding of the publicly funded healthcare system in Canada. These strategic investments include:

◆ *Establishing a CHST Cash Floor of $15 billion Immediately:* An immediate cash infusion at least $0.5 billion is needed to *stabilize* the existing publicly funded healthcare system and lay the foundation for longer-term sustainability of a broader continuum of care. CHA is urging the federal government to immediately commit (by April 1, 2000) at least $0.5 billion to raise the CHST cash transfer (the CHST supplement and the CHST cash floor) to $15 billion for the fiscal year 2000-2001.

◆ *Funding a National Home and Community Care Program:* A federal cash contribution is needed to ensure provincial and territorial commitment to new principles regarding access by Canadians to reasonably comparable, publicly funded home, community and long term care services across the country. These principles will need to be developed by the federal government in consultation with the provinces and territories. This commitment on the part of the provinces and territories can be facilitated through recent healthcare initiatives (such as the Health Accord and the Social Union agreement) and will go a long way to improving federal-provincial relations. CHA is urging the federal government to invest an initial $1 billion to support the development of a national home and community care program that will eventually be supported by a national pharmacare program.

◆ *Ensuring a Growth Factor for the Cash Component of the CHST:* CHA is also urging the federal government to apply a growth factor (or escalator) to the cash component of the CHST to ensure the long-term sustainability of our healthcare system. This growth factor (or escalator) should be introduced April 1, 2001, one year following the recommended increase in the cash floor to $15 billion. This reasonable growth factor should help to address future increases in the demand for health services anticipated by a growing and aging population, changes in heath needs, economic growth, changing labour dynamics, and innovations in technologies.

◆ *Exploring New Funding Mechanisms:* CHA is also urging the federal government, in consultation with the provincial and territorial governments and healthcare organizations, to explore new funding mechanisms for healthcare. In terms of specific new funding mechanisms, it should be noted that:

  - CHA does not support the call by some groups to transfer tax points to the provinces. CHA is concerned that reductions in the population of some provinces and other economic factors may mean that the tax base of certain provinces may be insufficient to provide for long-term funding and that access to comparable services across the country would be compromised. Therefore, CHA supports a combination of tax points and a cash floor for federal transfers for healthcare.

- CHA also does not support the call by other groups for more private sector financing of our healthcare syste. As Charles Baillie, Chair and CEO of the TD Bank noted recently: "To set aside our single-payer, publicly funded universal healthcare system would not simply be a moral error, it would be a grave economic error as well. The fact is, the free market, efficient and desirable as it is, cannot work in the context of universal healthcare."

CHA is working with our HEAL (Health Action Lobby) partners to undertake a study of alternative federal funding mechanisms. We look forward to sharing our findings with the federal, provincial and territorial governments.

- *Monitoring and Evaluating the Extent of Private Sector Financing and Delivery, and Developing National Standards:* With the increased involvement of the private sector in the funding and delivery of healthcare in Canada, CHA is urging the federal government, in collaboration with the provincial and territorial governments, to:
  - support the development of a transparent and active monitoring and evaluation process related to private sector financing and delivery within the Canadian healthcare system; and
  - develop national standards for the involvement of the private sector in the delivery of healthcare services.

With better information and clear standards of care, adjustments can be made in the public-private mix to ensure a sustainable, publicly funded healthcare system for the new millennium.

In addition to these strategic investments by the federal government, similar commitments will be needed by the provincial and territorial governments to ensure sufficient and long term funding is available for health systems across Canada.

While the health needs and priorities of each province and territory may be different, what is the same is the need for sufficient and long term funding to ensure that all Canadians have access to reasonably comparable services where and when they need them.

CHA and our member organizations are committed to using these needed additional resources to create a sustainable, accessible, accountable, integrated and publicly funded system that will meet the current and future needs of Canadians, and to foster a competitive advantage for Canadians in the global economy.

NEXT STEPS

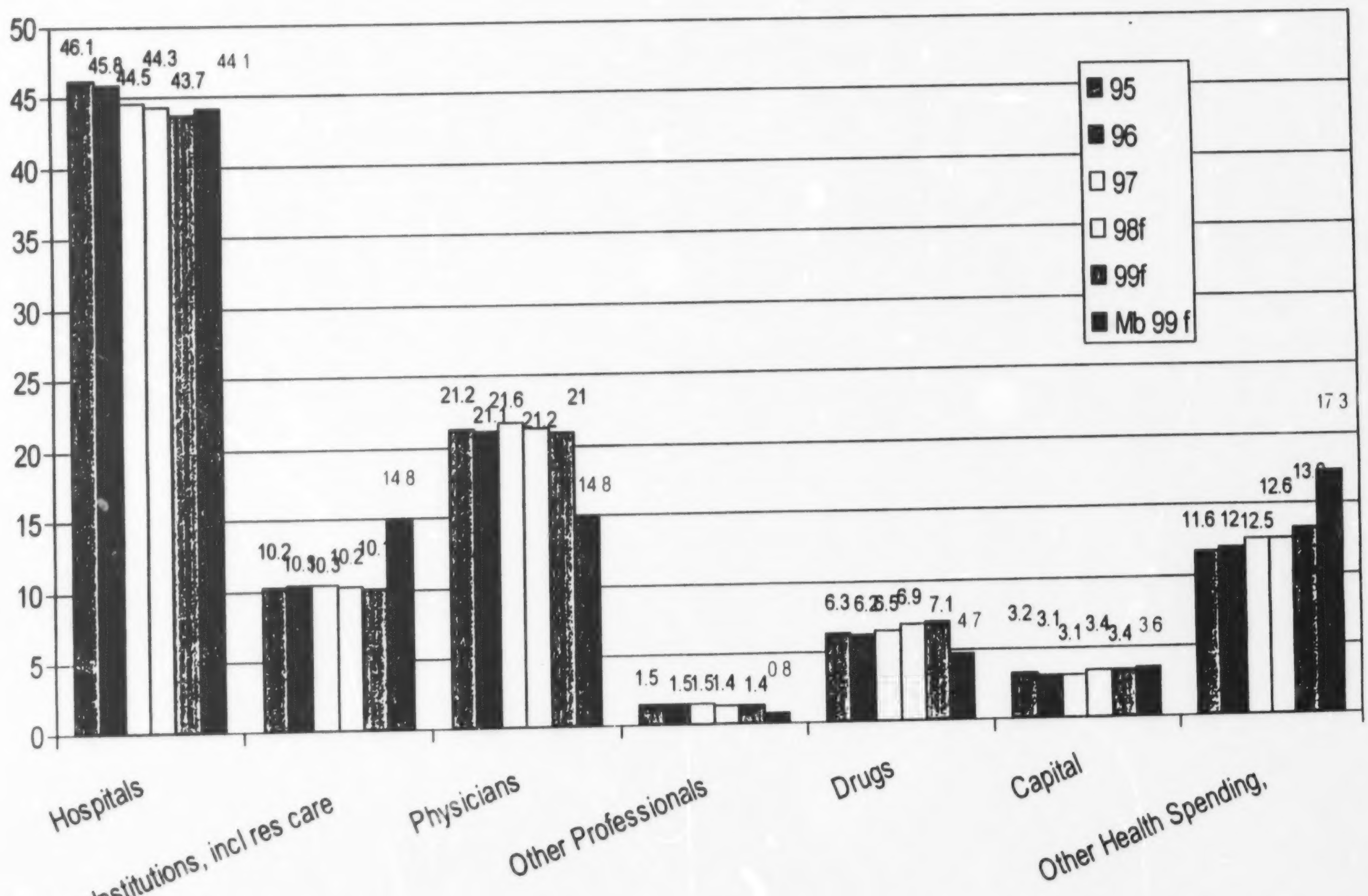
Creating a sustainable healthcare system is not just about money — it is also about leadership. Canadians expect healthcare facilities and agencies, healthcare providers, non-governmental organizations, and all levels of government to work collaboratively to create a sustainable healthcare system that will be there for them and their families.

The Canadian Healthcare Association looks forward to working with others to facilitate public discussion and debate regarding maintaining and improving our healthcare system; identifying potential solutions for addressing the many challenges facing the system; and implementing effective solutions to ensure a sustainable, innovative, integrated, accountable and publicly funded healthcare system.

It is hoped that this discussion will be valuable resource in this public discussion and implementation of effective solutions. A workshop kit is also being developed to help providers, managers, trustees, government decision makers and the general public review CHA's Sustainability Framework and make comments and suggestions for further action. Comments can be directed to the Canadian Healthcare Association or to our provincial and territorial member hospital and health organizations.

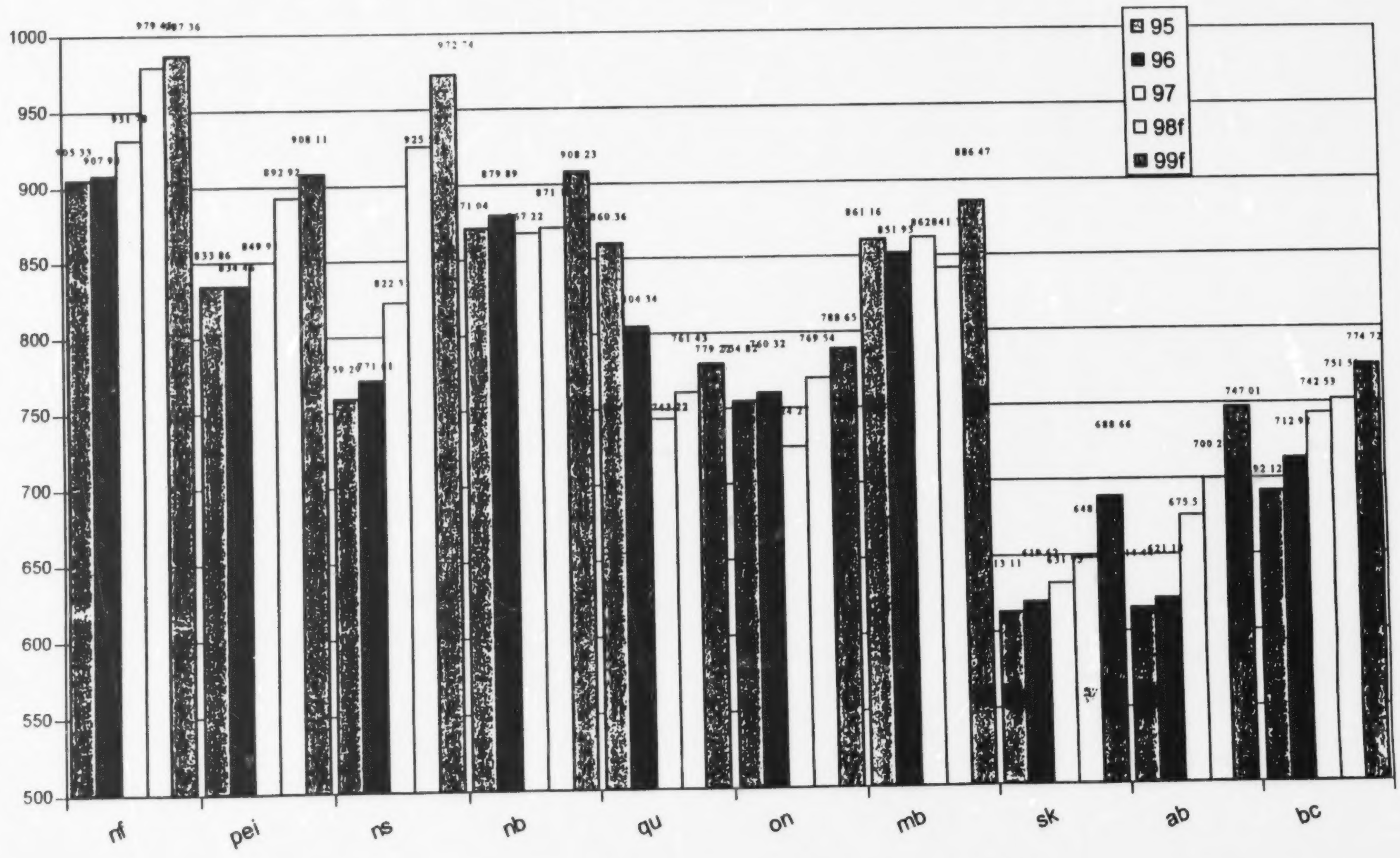
Together we can create a sustainable healthcare system that is responsive to the needs of all Canadians in the new millennium.

Provincial Expenditure, by use of funds (Canada average compared to Mb)



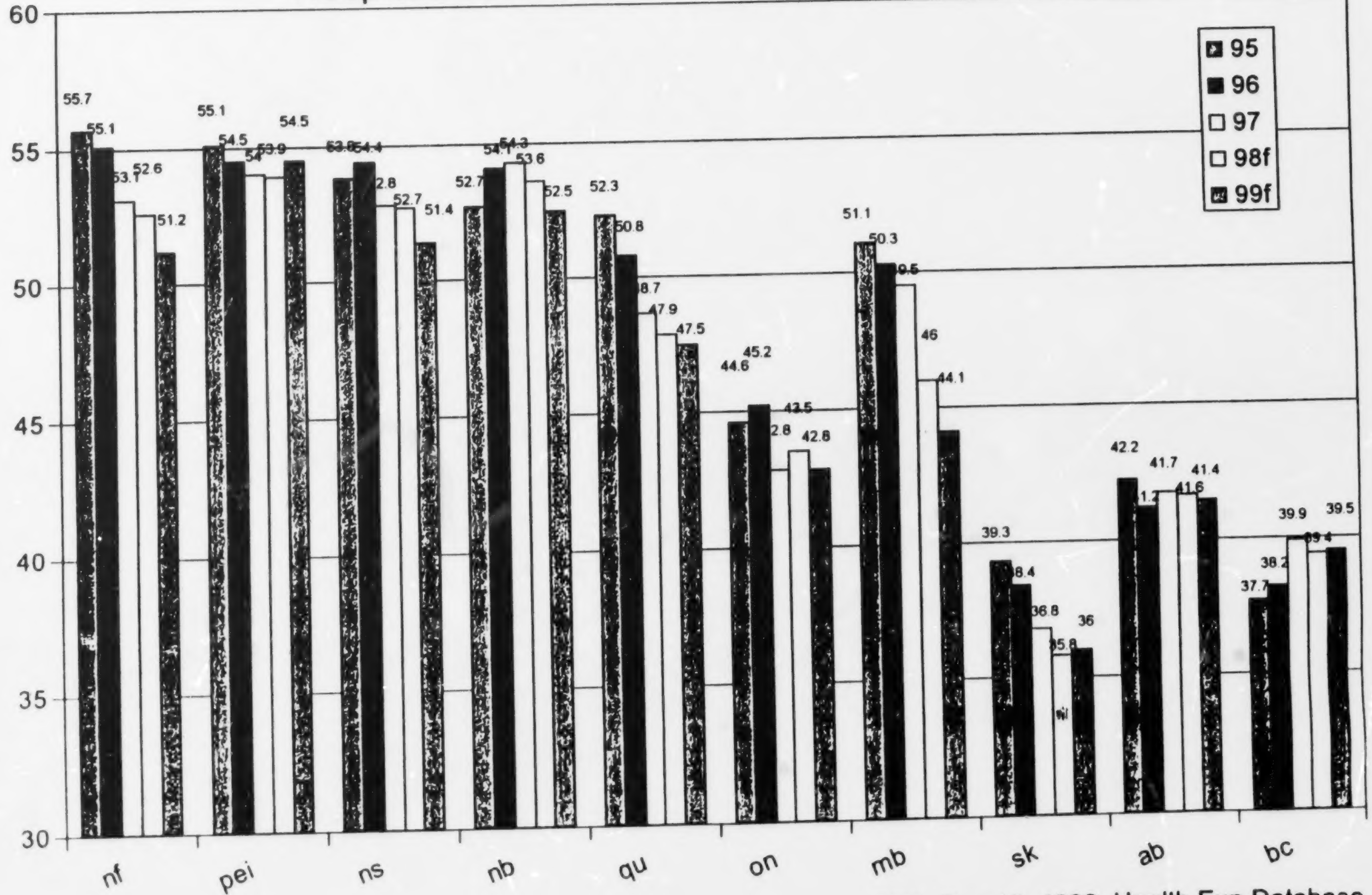
CIHI, Dec 16, 1999 Health Exp Database

Hospitals as $ per Cap, Prov Health Expenditures



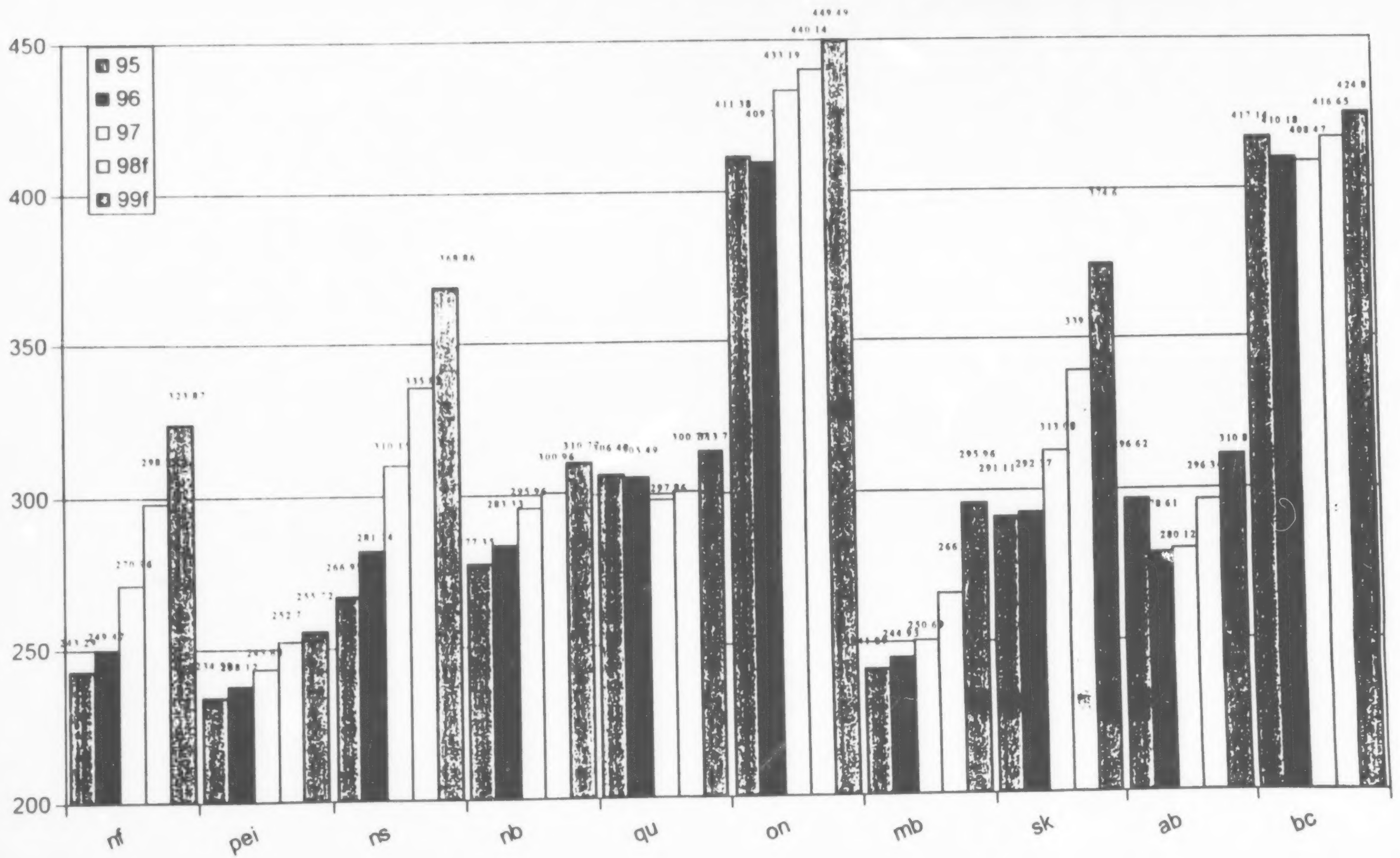
CIHI, Dec 16, 1999 Health Exp Database

Hospitals as a % of Total Health Expenditure



CIHI, Dec 16, 1999 Health Exp Database

Physicians as $ per Cap, Prov Health Expenditures



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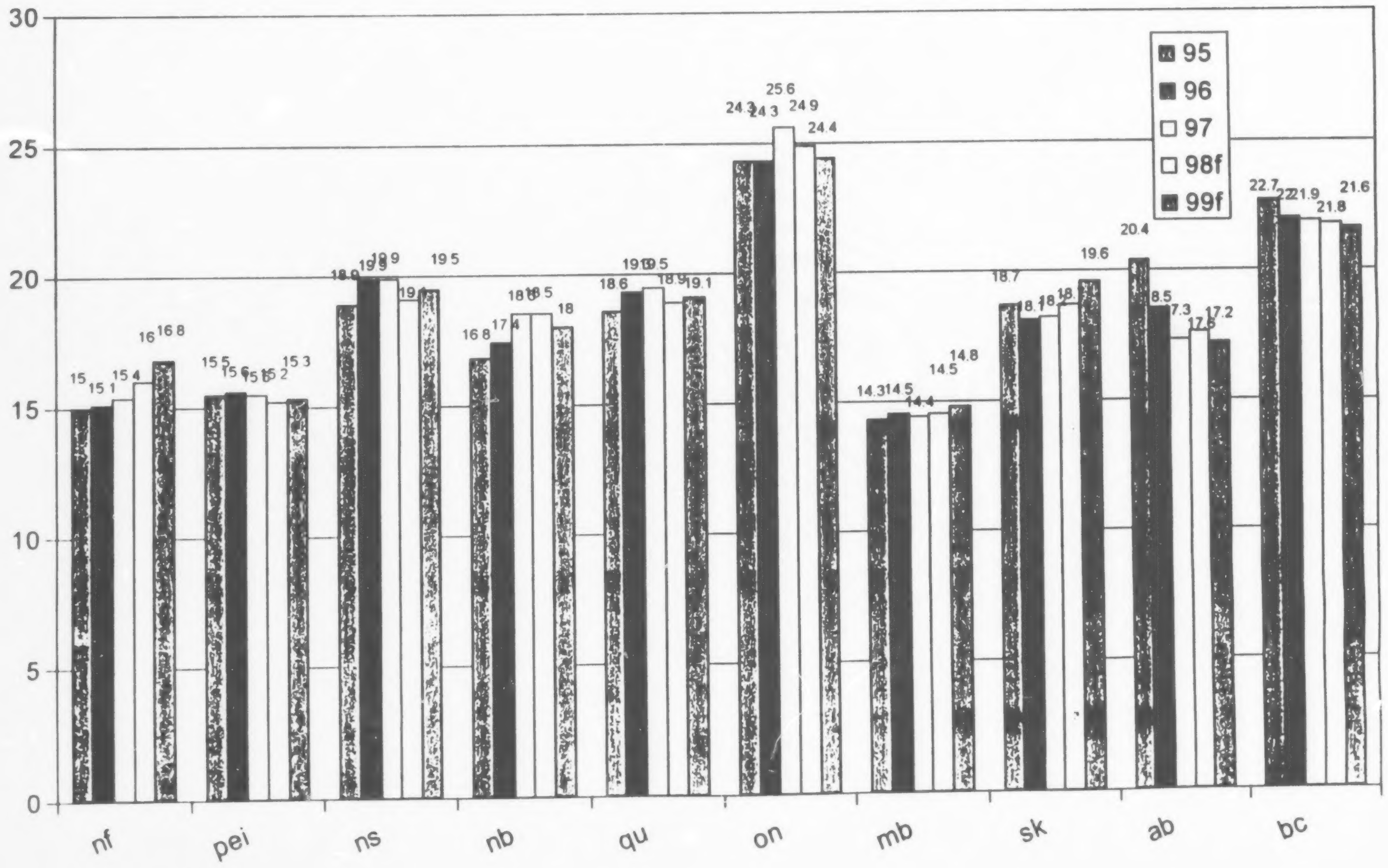
Physicians as % of Total Health Expenditure



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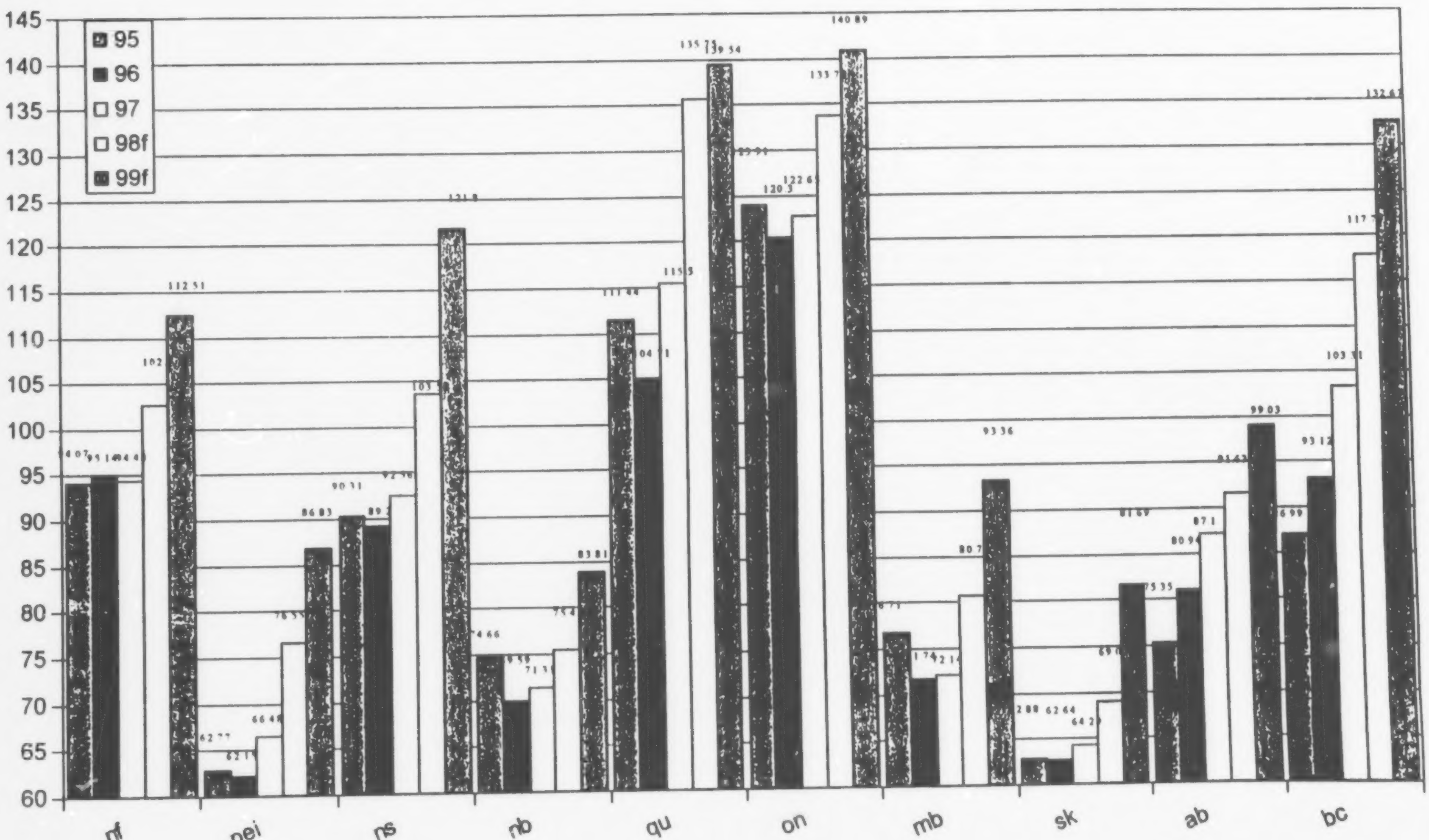
Drugs as $ per Cap, Prov Health Expenditures



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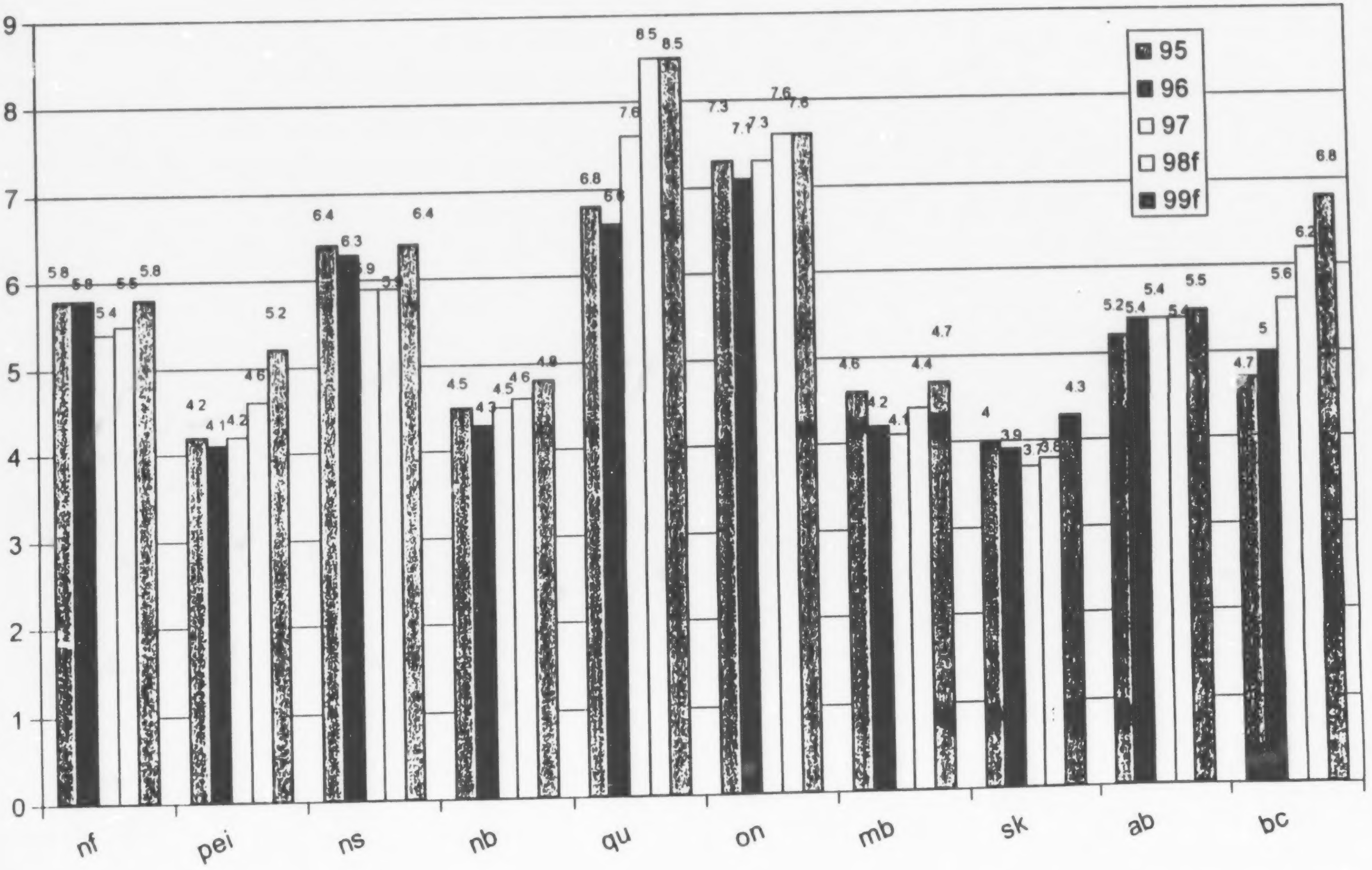
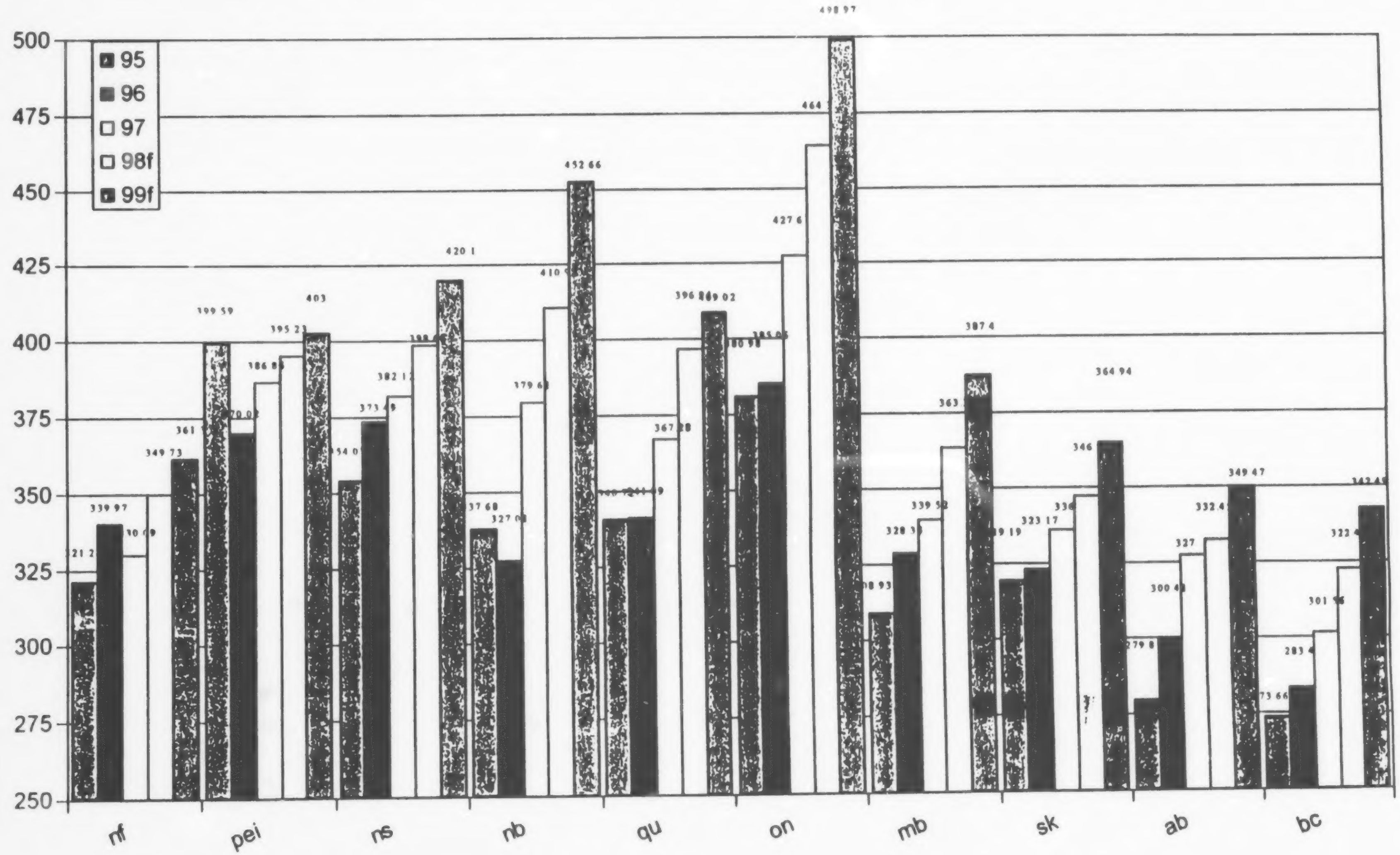
Drugs as % of Total Health Expenditure



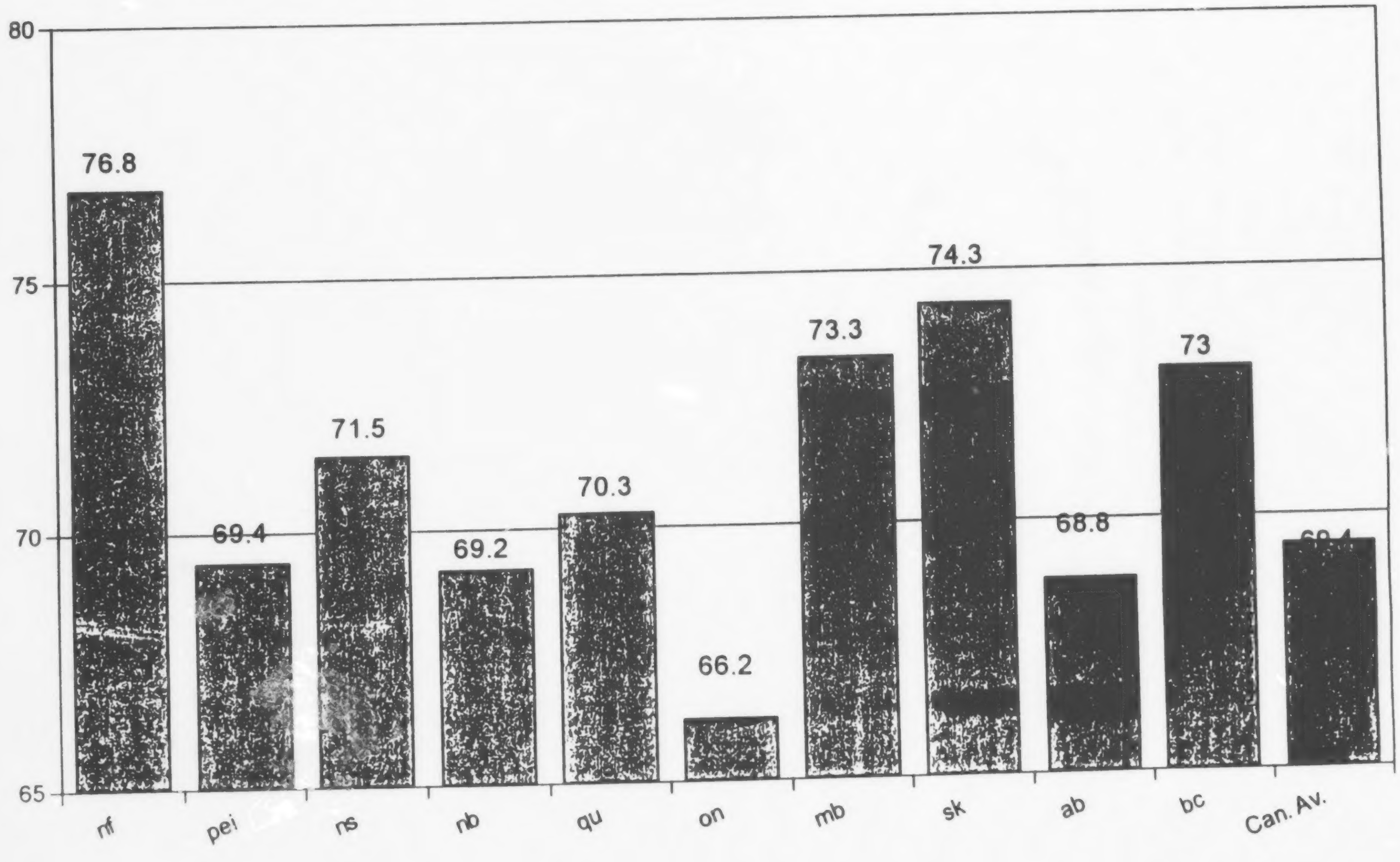
CIHI, Dec 16, 1999 Health Exp Database

Drugs as $ per Cap, Total Health Expenditures - all sources, public and private



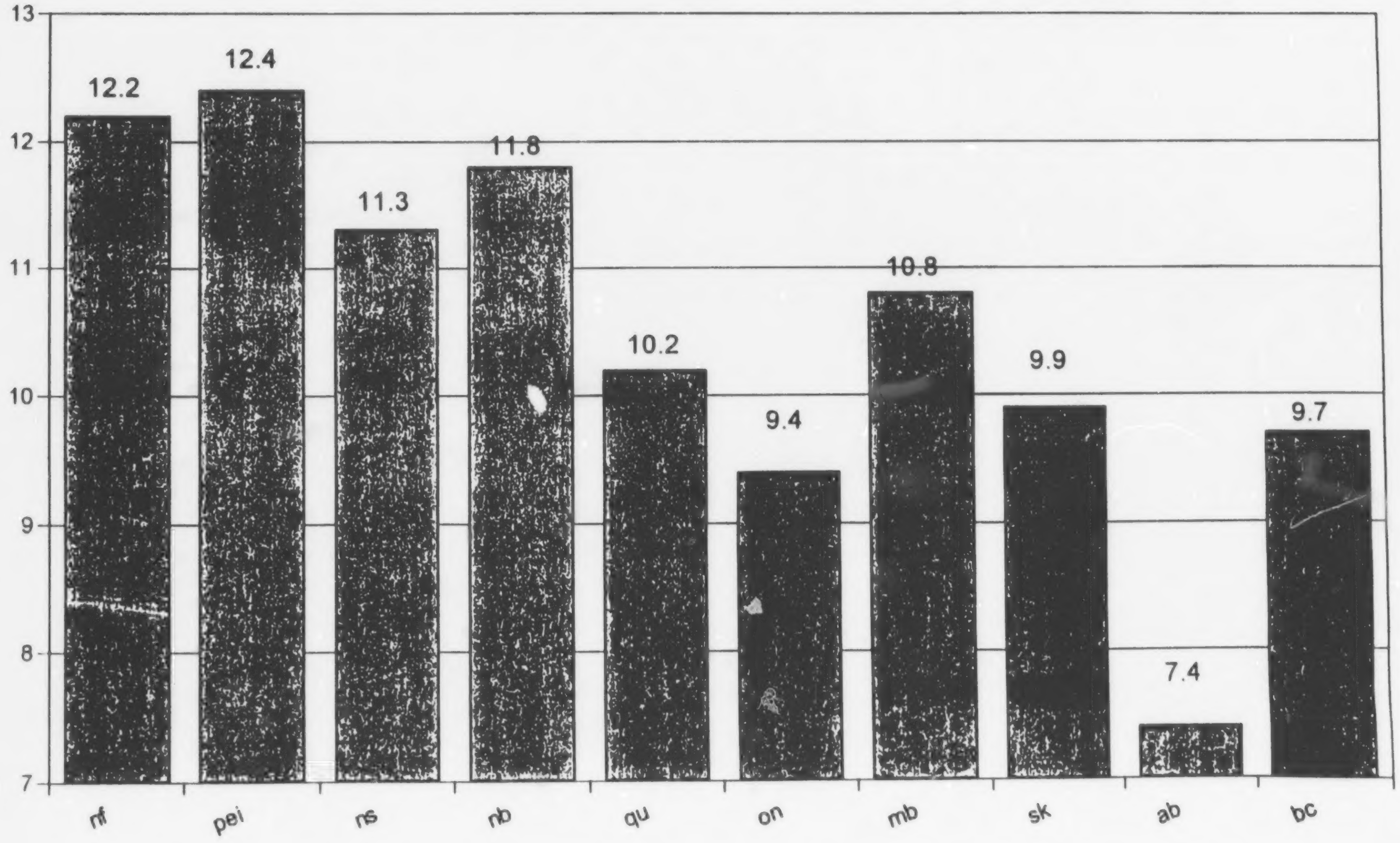
CIHI, Dec 16, 1999 Health Exp Database

Public Sector as % of total Health Exp, 1997



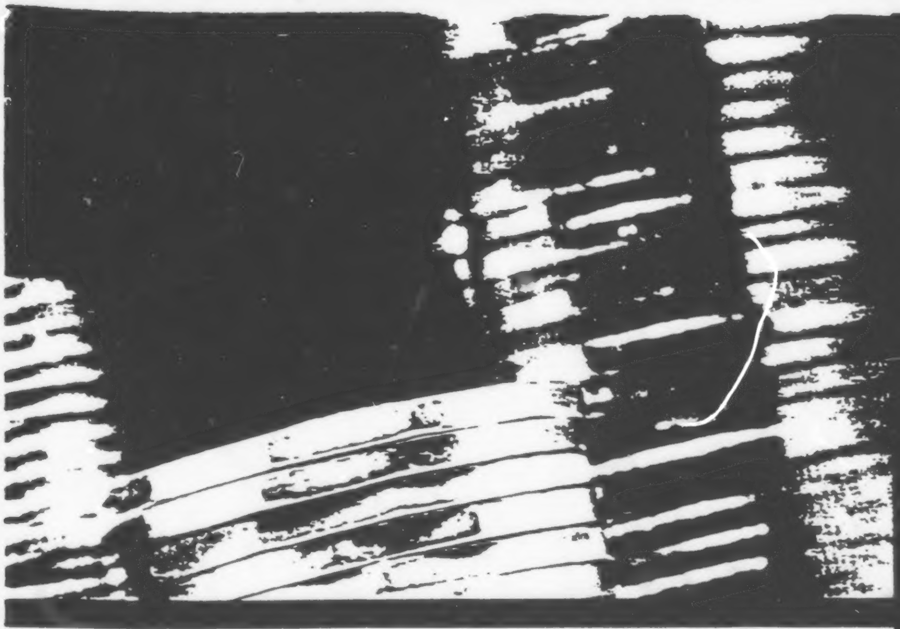
CIHI, Dec 16, 1999 Health Exp Database

Health Exp as % of Gross Domestic Product, 1997



CIHI, Dec 16, 1999 Health Exp Database

Appendix D



Achieving Accountability

Manitoba
Health

Acknowledgments

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August 1999

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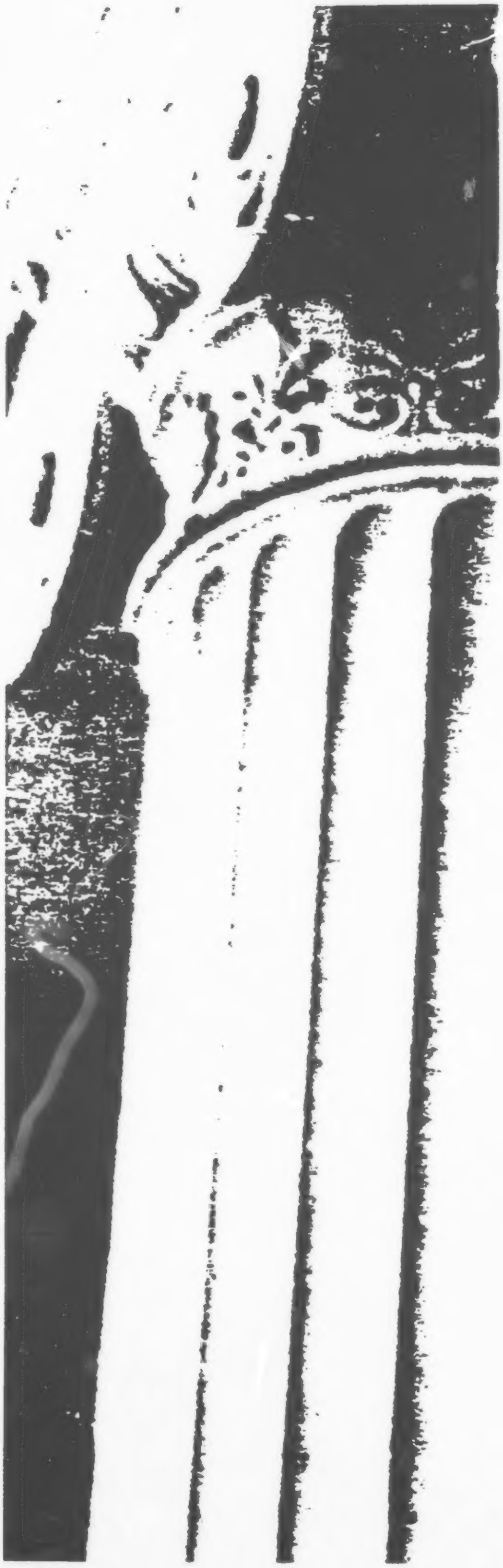

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Achieving Accountability

Introduction

The decision to regionalize the operation and administration of health in Manitoba is a major change in the way that health care is planned and delivered. The Regional Health Authorities (RHAs) are responsible within the context of broad provincial policy direction, for assessing and prioritizing needs and health goals, and developing and managing an integrated approach to their own health care system.[1]

Improvement in the overall quality of Manitoba's health care system requires a new focus on accountability. Responsibilities need to be clearly assigned, expectations set, and performance of the system reported on and monitored.

The Regional Health Authorities Act legislation came into force in 1997. It was amended in June of 1997 by the Regional Health Authorities Amendment Act. It sets out the conditions under which the RHAs are incorporated, as well as defining duties and responsibilities of the RHAs and the Minister of Health. Although both parties are responsible for policy, assessment of health status and ensuring effective health planning and delivery, the focus of these responsibilities are different.

The purpose of this discussion document is to define accountability relationships within Manitoba's health care system. The primary relationship is between the Minister of Health and the RHAs. Other relationships that flow from this primary relationship, although identified in this document, are not fully outlined.

I What is Accountability?

The Manitoba Government is committed to results-oriented, open, accountable government. The people of Manitoba have the right to know what health services are being delivered and what results are being achieved. This is known as accountability. The following definition of accountability is used extensively in health care literature.

Accountability is the obligation to answer for a responsibility that has been conferred.

"To be accountable implies a formal relationship and...it also implies a prior act of delegation direct from one party to another."[2] For an accountability framework, it is important to focus on formal lines of authority—areas where responsibilities have been developed, expectations are clear, reporting is required and performance is evaluated.

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[1] Manitoba Health. *A Planning Framework to Promote, Preserve and Protect the Health of Manitobans*, 1996.

[2] Timothy W. Plumptre. *Beyond the Bottom Line Management in Government*, Institute for Research on Public Policy, Halifax, Nova Scotia. 1988.

II What is the Accountability Process?

Figure 1 illustrates a conceptual model depicting the key elements in an accountability relationship. Together these elements form a "wheel" providing for a continuous feedback loop of accountability.

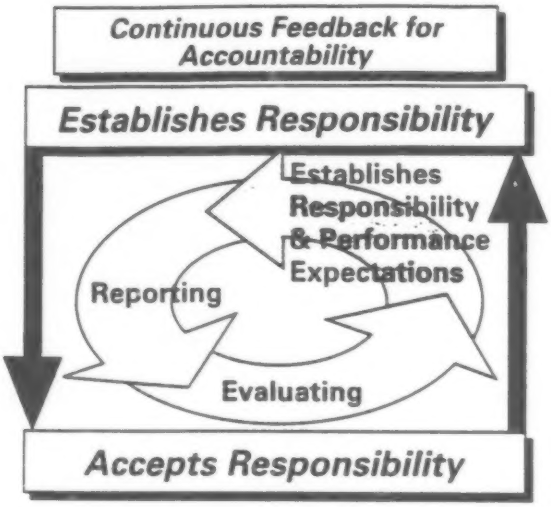

Continuous Feedback for Accountability
Establishes Responsibility
Establishes Responsibility & Performance Expectations
Reporting
Evaluating
Accepts Responsibility

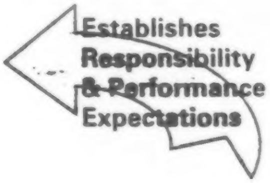
Figure 1

Several important elements underlie effective accountability relationships:

- roles and responsibilities are understood;
- performance expectations are explicit;
- resources are provided, including spending authority for same;
- review and feedback are carried out, and,
- follow-up actions, including rewards and sanctions, can be used to improve future performance

Establishing Responsibilities/Expectations

In any accountability relationship, the process will usually begin by establishing the responsibilities and expectations of the relationship.


Establishes Responsibility & Performance Expectations

Reporting

This phase involves some method of measuring outcomes, performance or progress toward meeting the defined responsibilities and expectations.

Evaluating

This phase involves analyzing the information and performance reports received during the reporting phase and making decisions based on that information.

Evaluating

III How Does Accountability Work

The purpose of this section is to outline the accountability relationships in Manitoba's health care system and, more specifically, between the Minister of Health and the RHAs. Figure 2 outlines the flow of accountability and relationships.

Legislative Assembly

The Regional Health Authority Act passed by the ***Legislative Assembly*** authorizes the delegation of responsibility and defines the limits under which actions can be taken or services provided. All other procedures that delegate powers and responsibilities to RHAs (such as provincial policy and/or guidelines) operate within limits of this legislation. Ensuring accountability and effective management in government departments such as Manitoba Health is the function of the office of the independent **Provincial Auditor** who reports to the Legislative Assembly.

Cabinet

Cabinet confers on the ***Minister of Health*** the final accountability and overall responsibility for the health care system. The Minister is accountable to Cabinet while also being accountable to the people of Manitoba through the Legislative Assembly. Through election of **Members of the Legislative Assembly (MLAs)** the public has access to the Legislature and lawmaking.

The Minister is responsible for planning and implementing strategic direction and provincial policy, prescribing health services that must be provided or made available, developing standards, monitoring and evaluating, and funding the provincial health care system.

The Minister has responsibility and authority to establish the expectations related to the Minister's delegation of responsibility and authority to the RHAs, and to ensure that those expectations are effectively communicated to all RHAs.

Different methods are used by the Minister to identify responsibilities and expectations of the RHAs, such as legislation, regulations,

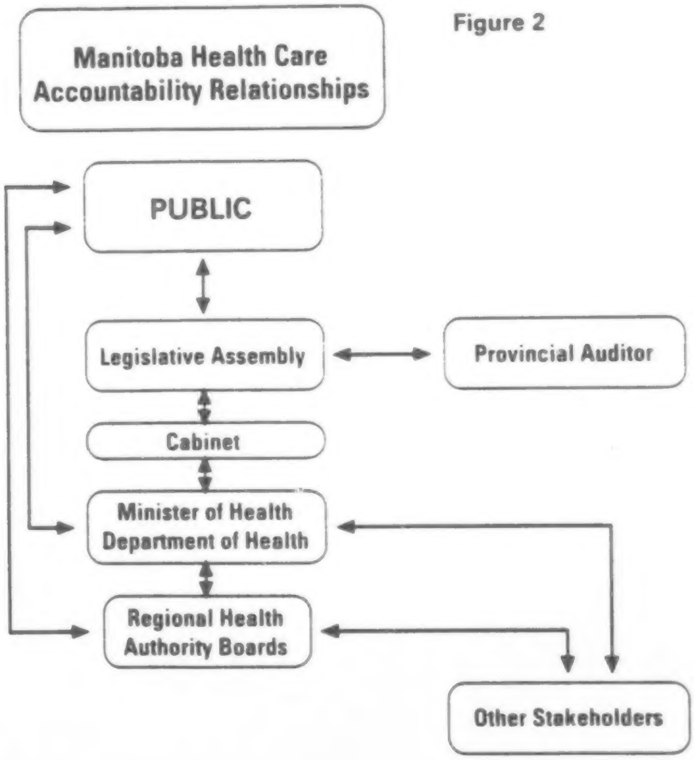


Figure 2

ministerial directions, policy and guidelines. The Minister also provides the necessary information and support that the RHAs need to meet the Minister's expectations.

Manitoba Health exists to act as an agent of the Minister to assist the Minister in performing the responsibilities conferred on him by the Legislature and to support the Minister in all his duties.

Regional Health Authorities

Regional Health Authorities have been given the legislated responsibility and authority to plan, manage, deliver, monitor and evaluate health services within their regions. They will have input into the development of provincial policy and planning direction, as well as into standards development. They are responsible for implementing and establishing a sustainable, integrated system of health services.

RHAs have an obligation to be aware of and carry out all expectations and responsibilities that have been established, seek clarification if they are unclear, and recommend changes where they feel necessary.

As the relationship between the Minister and the RHAs evolves, it will be necessary to jointly review the responsibilities and expectations on an ongoing basis to ensure that they are increasingly focused on outcomes.

The joint development process will be carried out through forums such as the RHA Council of Chairs, which advises to the Minister and has an ongoing dialogue with the Minister regarding RHA board issues.

Other Stakeholders

Other stakeholders in health including the many non-governmental organizations, foundations, charitable groups, providers, consumers, volunteers and individuals who are recognized for the essential contributions they make to the effective functioning of the health care system and the resulting health of Manitobans. They are not discussed in this document due to its specific focus on public-sector accountability.

The following chart is adapted from *A Planning Framework to Promote, Preserve and Protect the Health of Manitobans* (Manitoba Health, 1996). It illustrates some of the responsibilities of the Minister and the RHAs.

	Health Minister Responsibility	**RHA Responsibility**
Policy guides actions, sets broad strategies	• develops provincial strategies • facilitates co-ordination of strategies across regions	• develops regional strategies • participates in development of strategies across regions
Assessment determines & prioritizes needs, identifies resources	• assesses provincial health status & health needs • determines provincial priorities • establishes standards for community health assessment	• assesses regional health status & health needs • determines regional priorities • carries out community needs assessment
Assurance ensures management and delivery of services, includes monitoring & evaluation	• ensures needed legislation • determines core services • establishes and monitors standards • ensures accountability for public spending • approves health plan • leads, participates in research initiatives & communications findings	• manages organization & delivery of services • develops & submits health plan • monitors services in terms of standards • monitors effectiveness of action in terms of impact on health • initiates practice-based research & participates in provincial research

IV Summary

This document provides a review of the evolving accountability relationship between the Minister of Health and RHA Boards. It explains the accountability framework, using the three key elements of the accountability "wheel" or "loop", establishing responsibilities and expectations, measurement and review.

As Manitoba's health system evolves toward a system based on outcomes and wellness, the accountability relationships within that system will continue to evolve. Specifically, accountability will move from its past focus on finances. It will be increasingly measured in terms of outcomes, health of the population and the overall benefits resulting from resources invested. This change will ensure that good value is received for the time, money and other resources invested in those programs and services.

Appendix E

Winnipeg
Community & Long Term Care
Authority

Office des soins communautaires
et de longue durée de Winnipeg

Winnipeg Hospital Authority
Office des hôpitaux de Winnipeg

Synopsis of the Information Systems Strategies of The Winnipeg Community & Long Term Care Authority and The Winnipeg Hospital Authority

A Joint Submission to the Government of Manitoba

April 23, 1999

Synopsis of the Information Systems Strategies
of
The Winnipeg Community & Long Term Care Authority
and
The Winnipeg Hospital Authority

A Joint Submission to the Government of Manitoba

1. Introduction

A major restructuring of health care resources is taking place in Winnipeg. The result will be a seamless continuum of health services—for the benefit of the residents of Winnipeg and the Province of Manitoba. The continuum includes a number of providers including the Winnipeg Community & Long Term Care Authority (WCA) and the Winnipeg Hospital Authority (WHA).

This document is a joint submission by the WCA and WHA. This submission describes the **vital role** that a comprehensive suite of information systems will play in enabling the WCA and WHA to achieve their goals with respect to client service, operational efficiency and decision-making capabilities. The information systems initiative of the WCA and WHA is one of many initiatives currently underway in Manitoba to provide better access to service, better service delivery and consistent/shared reporting of information.

This document is based on the information systems strategic plans that were developed in 1998 by the WCA and WHA. Note that, although it is not part of the WHA, the Manitoba Cancer Treatment & Research Foundation (MCTRF) participated in the WHA's information systems planning process.

This document also describes:

- The complex information management challenges the WCA and WHA face
- The sophisticated information systems that the WCA and WHA require in order to cope with their information management challenges
- An overview of the benefits that will accrue to the residents of Winnipeg and the Province through the use of comprehensive information systems
- The structure of the joint project that will manage the implementation of the required information systems
- The implementation timetable and estimated costs for the information systems implementation project.

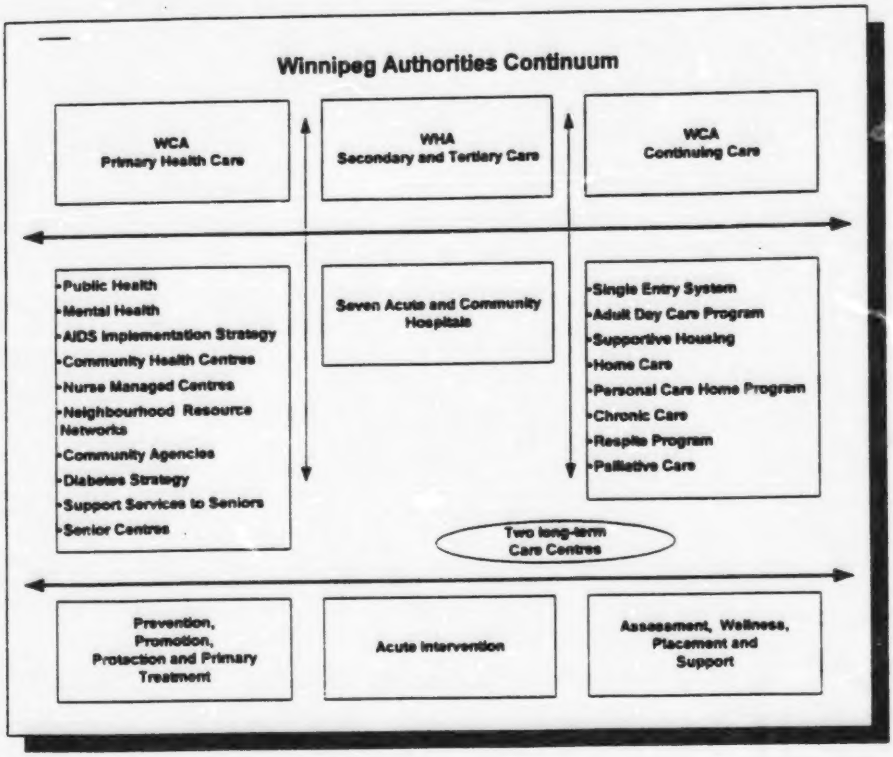
2. Background

A fundamental reorganization of health services in the Province of Manitoba is underway. Thirteen regional health authorities are responsible for the planning and management of the majority of provincially funded health services—excluding the Physician Fee for Service component. The health system in Winnipeg is managed by two Authorities—the Winnipeg Community & Long Term Care Authority (WCA) and the Winnipeg Hospital Authority (WHA). It is envisioned that the two Authorities will provide a "seamless continuum" of health services. The current overlapping membership of the WCA and WHA—at both the Board and senior management levels—was designed to promote integration, coordination and decision making from a system wide perspective. These two Authorities will eventually be consolidated into one organization.

In addition to the WCA and WHA, the Manitoba Cancer Treatment and Research Foundation (MCTRF) is also an integral part of the health care services located in Winnipeg and would have to be part of any information systems initiative.

As Exhibit 1 illustrates, the WCA and the WHA are jointly responsible for a wide range of health care services in the Winnipeg region.

Exhibit 1
The Winnipeg Authorities Continuum


Winnipeg Authorities Continuum
WCA
Primary Health Care
WHA
Secondary and Tertiary Care
WCA
Continuing Care
•Public Health
•Mental Health
•AIDS Implementation Strategy
•Community Health Centres
•Nurse Managed Centres
•Neighbourhood Resource Networks
•Community Agencies
•Diabetes Strategy
•Support Services to Seniors
•Senior Centres
Seven Acute and Community Hospitals
•Single Entry System
•Adult Day Care Program
•Supportive Housing
•Home Care
•Personal Care Home Program
•Chronic Care
•Respite Program
•Palliative Care
Two long-term Care Centres
Prevention, Promotion, Protection and Primary Treatment
Acute Intervention
Assessment, Wellness, Placement and Support

* WCA oversees a number of funded agencies

3. Sophisticated Information Systems Are Absolutely Essential

Clearly, the effective and efficient delivery of the full spectrum of health services—including planning, client service, evaluation and research—presents a daunting information management challenge for any healthcare organization. For organizations as multifaceted and physically dispersed as the Winnipeg health authorities, the challenge can seem almost overwhelming.

From an information management standpoint, the goal is to provide "the right information, at the right time, in the right place and in the right format." This means that the sophisticated computer-based information systems are an absolute necessity—to support day-to-day operations as well as to enable coordinated service planning, delivery and evaluation.

4. The Current Information Management Tools Are Grossly Inadequate

The WHA and WCA inherited their current information systems from the predecessor organizations. Although these tools may have been adequate at some point in the past, by today's standards they are grossly inadequate to support the mission of integrated, multifaceted organizations such as the WCA and WHA.

The current status of these tools can be summarized as follows:

- **The WHA:** The systems currently installed in the hospitals comprising the WHA are **inadequate** to meet the mission of the WHA. Although each of the hospitals has made investments in administrative and clinical support information systems, most of these systems have modest functionality and are incomplete. Also, the existing systems were not designed to support a regional health authority and so do not provide for a regional patient/client record and other regional functions. Furthermore, many differences exist among the systems, resulting in differing procedures among the hospitals. Finally, many of the current systems are not Year 2000 compliant or are no longer supported by the vendors that provided them.
- **The WCA:** Currently, the WCA has very little information technology. As noted, the existing systems were inherited from the various predecessor organizations that comprise the WCA. Some of the predecessor organizations had no information technology. Of the automated systems inherited, many are based on obsolete technology, provide inadequate functionality, do not have vendor support, are based on incompatible technologies and were not designed for a regional organization. Furthermore, some of the existing systems are not Year 2000 compliant. In short, the extremely low level of information technology within the WCA is inadequate to support the WCA's mission.

Recognizing the inadequacy of the existing systems, the WCA and WHA engaged PricewaterhouseCoopers to develop a Vision and Strategic Plan for each Authority. Copies of these documents are available. The purpose of this submission is to integrate these plans into one consolidated approach for our technology challenges.

In summary, both the WHA and the WCA will be unable to meet their missions with the existing information systems. A major overhaul and investment in information systems is essential, if the goal of providing seamless and timely service across the continuum of care is to be achieved.

5. Outline of the Proposed Information Management Tools

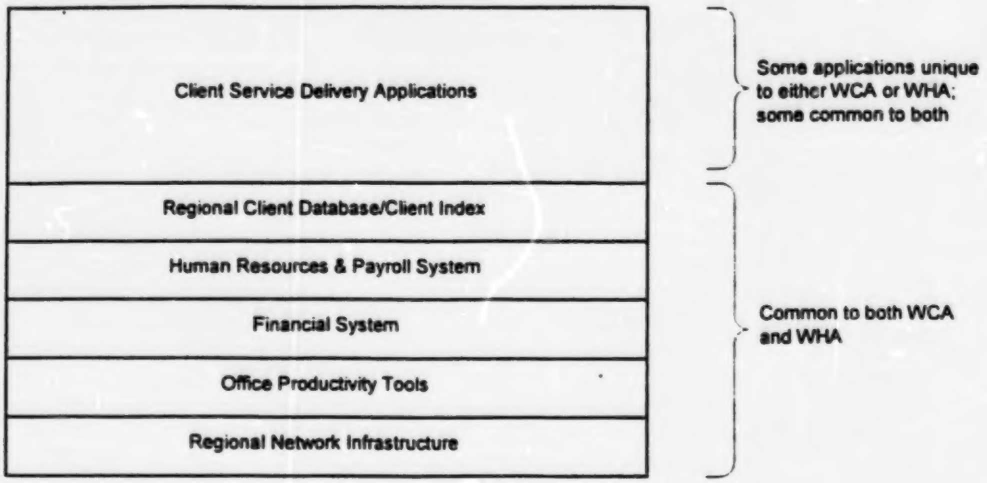
The information management tools that the two Authorities propose to acquire consist of a number of components, including:

- Computer applications to meet the clinical and business needs of the two Authorities. These applications will support a variety of functions including:
    - Client service scheduling and admission/registration
    - Client assessment and service planning
    - Clinical documentation
    - Management of diagnostic testing and drug distribution
    - Outcomes measurement and research
    - Office automation tools including electronic mail
    - Administrative functions such as financial, human resources and materials management
    - Planning, costing and performance measurement
- A telecommunications network, linking all of the providers and sites of the WCA and WHA
- Computer workstations (including mobile devices for mobile staff), large scale processors and high capacity data storage equipment
- Links via the HIN with the DPIN and DSIN databases, other RHA's and other external organizations such as Manitoba Health and the Manitoba Centre for Health Policy and Evaluation (MCHPE).
- Security features to protect personal information from unauthorized access and to ensure compliance with the Province's PHIA and FIPA legislation.

Although the WCA and WHA both provide health services to clients, the nature of their services is quite different. As depicted in Exhibit 1, the WCA is responsible for a wide range of community based services and long term care services provided in a variety of institutions and settings. WHA's mandate focuses on the nine hospitals in the city. Consequently, some of the information management tools used by the WCA to support clinical functions will not be suitable for the WHA, and vice versa. On the other hand, both Authorities can use the same information management tools used to support administrative functions, patient/client registries and can share the same infrastructure and regional databases.

Exhibit 2 illustrates a conceptual view of the information systems of the WCA and WHA, and highlights the areas of similarity and uniqueness.

Exhibit 2
Conceptual view of the WCA/WHA information systems


Client Service Delivery Applications
Regional Client Database/Client Index
Human Resources & Payroll System
Financial System
Office Productivity Tools
Regional Network Infrastructure
Some applications unique to either WCA or WHA; some common to both
Common to both WCA and WHA

6. The Benefits

The operations of modern health care organizations are extremely complex, involving teamwork among a variety of clinical, administrative and support staff. In health care organizations, a vast amount of information is collected, stored, retrieved and manipulated to support effective delivery of patient/client services, as well as effective management of financial, human and physical resources. In addition, a significant amount of information is collected and reported to meet government regulatory requirements. In fact, the health care industry is often compared with other information-intensive industries such as banking and airlines, in terms of its need for effective information management tools.

Effective information systems can enable three types of benefits:

- Direct cost savings—such as labour savings, less duplication, less wastage.
- Cost avoidance—the ability to avoid a future expenditure.
- Service benefits—the ability to provide more timely, more appropriate service, or to provide the service with fewer errors—clearly significant in a health care setting.

A review of relevant literature and the consultants' own experience indicates that many of the benefits of the planned systems—especially the components that directly support the delivery of care—will be of a qualitative nature. Key objectives of these components are to improve the quality and timeliness of service, reduce errors and improve service levels.

Information systems in a health care environment typically cannot be justified solely on the basis of cost savings. However, they do provide substantial opportunities for service benefits—in terms of providing more accessible, complete, accurate and timely information to clinicians, researchers and managers, enabling them to make better decisions, reduce duplication, improve consistency and generally provide better care to clients/patients. Better information coupled with clinical alerts and reminders also support improved care and services. In fact, given that health care is a service industry, justification on the basis of service benefits is considered to be very appropriate.

As the highly respected GartnerGroup research organization has stated: "CIOs and senior IT managers must be well-versed in various financial justification methods. These methods are best used in combination, as the strengths of one method often compensate for the deficiencies of another. It is also important to note that while financial justification methods are critical in determining ROI, none of them necessarily determine IT contribution and value. **We emphasize that IT contribution must be measured against the value of the business strategy it is intended to support.**" [1]

6.1 Benefits to the Consumer

The comprehensive, integrated information systems envisioned by the WCA and WHA will enable the provision of effective and efficient health services and health information to the residents of Winnipeg and the Province of Manitoba. Examples of the benefits associated with effective, integrated health information systems include:

- Improved service due to availability of patient and clinical information which can be exchanged among the different components of the health system/continuum supported by integrated information systems. In this context, the goal is availability and access to integrated information related to the services of Health, Family Services, Education, and Justice. For example:
  - A Home Care Or Antenatal case manager would have access to information regarding a client's health services (acute and community based), as well as access to relevant information regarding other services the client is receiving involving sectors such as Family Services and Education. This level of integration can assist providers with service coordination, reduce duplicate data collection and ensure a higher level of service for clients.
  - When a patient/client is discharged from a hospital to the community with orders for Home Care, relevant information would be immediately available to Home Care service providers.
  - When a person arrives at an Emergency department or is admitted to a hospital, hospital-based providers would have quick access to relevant client information, including the information regarding the client's encounters with other WCA or WHA facilities
- Improved service levels enabled by greater availability of client information, for use by multiple providers simultaneously—as opposed to a paper record that can be in only one place at a time
- Integrated information systems, shared by WCA and WHA, will enable the different providers and health care workers to coordinate interaction with a client, e.g. Antenatal program, Hospitals, Home Care, Public Health
- Improved utilization of resources enabled by reduced duplication, improved scheduling and streamlined information management processes

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[1] Introduction to Financial Justification Analysis, Healthcare Executive and Management Strategies, © GartnerGroup, February 24, 1999

- Greater customer convenience due to appointment schedules that reflect client/patient preference, in terms of location and timing and that can be arranged from home (over the Internet or by means of interactive voice response)
- Greater uniformity and effectiveness of clinical practices, through real time access to current research and information regarding best practices, and automated clinical practice guidelines
- Better health care planning, deployment of resources and interventions based on improved access to information including population health and utilization data
- Improved utilization of staff resources supported by staff scheduling tools designed to support compliance with collective agreements, and the tracking of credentials, skills and experience
- Improved utilization of limited resources such as operating rooms and diagnostic imaging equipment across the system supported by automated scheduling applications and utilization management tools
- Improved ability to create accountability at the provider and operational level by providing information on quality, cost and resource utilization at the provider and program level
- Greater protection for sensitive information than is possible with paper records, by means of robust security provisions, audit trails and system back up and recovery procedures
- Improved access to health information by clients/patients and their families enabling them to participate in and/or manage their own health
- Improved quality of service enabled by information systems [2] that include automated alerts, flags and rules to identify potential conflicts and contraindications. Tools such as these help to ensure that critical client/patient information is highlighted for providers
- Identification of opportunities for process improvements based on analysis of current activities and the identification of bottlenecks and delays
- Increased confidence in a health care system that employs current information management tools to capture and communicate information in timely and secure manner

6.2 Benefits to the System

The health care system of Winnipeg and Manitoba will benefit from the investment in information systems in a number of ways:

- The amount of staff time required for a wide range of functions will be reduced. These time savings can enable staff to carry out a greater volume of work, or to perform other tasks. Examples of functions that can be eliminated/reduced or performed more efficiently include:
  - Communication of information by telephone and fax
  - Manual completion of paper documentation

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[2] An integrated information system helps minimize repetitive tests, avoid medication contraindications, alerts caregivers to clinical events that need prompt attention and maximize treatment efficiency while controlling costs" Amatayakul, M. et al, Comprehensive Guide to Electronic Health Records, 1997, pg. 12

  - Transcription or data entry where information is entered into a computer system after the fact, or when information is re-entered into standalone systems
  - Manual preparation of appointment books and staff schedules
  - Recording and tracking personnel information
  - Manual recording of information in different locations to support timely access to information: health record, care plan, appointment books, Kardex, blood work sheets, work lists

- Improved reporting and analytical capability due to ready access to standards-based integrated patient medical/clinical information which could be used to measure, assess and improve health care delivery and management
- Improved management capability due to timely access to accurate human resources information, automated support for functions such as position control, monitoring and management of absenteeism, ability to assess labour costs associated with expanded or new programs
- Improved quality and consistency of information through the implementation of common systems among the nine hospitals of the WHA and the many components of the WCA
- Improved ability to leverage the IS skills base within the organization, because of standardized applications and technology
- Improved quality, completeness and timeliness of information will support research and analysis and improved use of resources
- Improved ability to perform case costing and related analyses to assess performance and resource utilization
- Improved ability to respond to information requests
- Reduced turnaround time for functions such diagnostic testing, from the time of service ordering to the time of result availability.
- Greater accuracy/lower error rate:
  - Order sets can be predefined to ensure completeness
  - Automated alerts, flags and rules can notify providers of potential conflicts and contraindications
  - Duplicate tests and medications can be highlighted at the point of order entry
- Automatic identification of high cost procedures or medications where lower cost options provide same quality outcome
- Improved consistency of treatment protocols through retrospective analysis
- Improved risk management due to more complete and comprehensive record keeping based on standardized information and documentation
- Better (or quicker) clinical decisions, as a result of more timely access to all relevant information, including reference to best practices and research information

6.3 Benefits to Government

The Government—and specifically, Manitoba Health—will benefit from the use c rehensive information systems by the WCA and WHA through:

- Improved resource utilization supported by improved ability to assess and mc opulation health needs and resource utilization by hospital, organization, program, prov ıd case mix group
- Ability to perform sophisticated and powerful analyses regarding the wellness eeds of the population, and the most appropriate interventions and services to meet thes s. The power of these analyses will be greatly enhanced through the ability to includ ant information from other related sectors, such as Education, Justice and Family :es
- Improved ability to monitor health care program performance on a timely basi
- Improved ability to target interventions and monitor impact of interventions
- Improved support for timely, system wide communication supported by a telec nications infrastructure and standardized office automation tools such as Electronic ma
- Improved tools to support its role in policy setting and performance monitorinc

6.4 Benefits to Other RHA's

The WCA and WHA are committed to jointly conducting a process of selecting ec nt, software and services. The primary goal is to acquire the most suitable products and serv ˉ the WCA and WHA. However, it is likely that other RHA's may be able to leverage from the gements made by the WCA and WHA.

To this end:

- The WCA and WHA will invite representatives of other RHA's to participate in tem selection process to the extent desired
- The contracts negotiated by the WCA and WHA will include provisions permitt other RHA's to participate in their hardware, software and service contracts, if they v ı this manner, they will be able to e the same terms and conditions.
- Furthermore, to the degree that the RHA's outside Winnipeg participate with th and WCA in the implementation of new systems, the greater similarity among the informa stems of all Manitoba RHA's will enhance the ability to exchange information among RH formation exchange can be very beneficial in a variety of situations such as the transfer c ient from the WCA and WHA to or from an RHA outside Winnipeg
- WCA and WHA will have a considerable IS resource pool with depth and expe at could provide some level of support to other RHA's

7. Leveraging Manitoba's Investments

The information systems of the WCA and WHA will leverage investments of the P of Manitoba. Specifically:

- The investments that the Province of Manitoba has committed to remedy Year 2000 exposures will likely fund about half of the computer workstations required by the WCA and WHA. In addition, the Province's Year 2000 project will be funding the replacement of several major applications used by the WHA that are not Year 2000 compliant.
- The WCA and WHA will work closely with Manitoba Health and the Government of Manitoba to take advantage of bulk purchasing opportunities of items such as personal computers, software and accessories.
- The Health Information Network (HIN) that the Government of Manitoba is building will be an integral part of the network infrastructure for the WCA and WHA. Consequently, the two Winnipeg Authorities will avoid the expense of this critical infrastructure component. Furthermore, the HIN will provide a robust, secure linkage between the Winnipeg Authorities and rural Authorities, as well as other organizations.
- The DPIN and DSIN databases will be linked with the corresponding databases maintained by the information systems of the WCA and WHA. Through this synchronization, the quality and timeliness of information will be enhanced, thereby benefiting client service.
- The WCA and WHA are well aware of the groundbreaking work being carried out by the Integrated Case Management (ICM) project. Where appropriate, the information systems of the WCA and WHA will be built on the ICM work.

8. Critical Success Factors

The migration to the suite of information systems needed by the WHA and WCA will be a complex and challenging process. Several factors that are critical to the success of the transition process, and the ongoing operation of the Health Authorities' information systems are described below.

- **Executive support**—The Executive and Boards of the two Authorities must provide unambiguous, active and sustained support for the joint information systems strategy.
- **Adequate funding**—Successful implementation of region-wide information systems will require adequate funding. Section 10 provides a summary of the estimated capital and operating funding requirements.
- **Information systems positioning and leadership**—Information systems will be a key enabler of the missions of both the WCA and the WHA. Similar to other key functions (e.g. Finance and Human Resources), it is essential that the leader of information systems should be a shared position supporting both Authorities. This will help to ensure integration, coordination and decision making from a system wide perspective and support the planned future consolidation of the two Authorities.

  It is imperative that the leader of Information Systems ensure that the needs of both Authorities are addressed and that the acute focus of hospital services does not overtake the very real, and equally important needs of the WCA and its entities.
- **The culture of the information systems function**—The information systems function supporting the WCA and WHA must have a culture that:
  - Focuses on the missions of the two Authorities—rather than on the predecessor organizations

  - Actively fosters a service orientation (as opposed to a control orientation)

- **Change management**—The introduction of the new information systems will result in profound organizational change. Therefore, it is imperative that the WCA and WHA—and the information systems function—develop a formal change management strategy.

  Process optimization will be critical if the WCA and WHA are to capture the benefits afforded by the regional authority organization structure and the new information systems.

- **Information management standards**—In order for the WCA, WHA and other health care organizations to share, exchange and fully utilize electronic health information, standard vocabularies and terminology are required. Many jurisdictions are attempting to address the issues related to health care terminology through standards organizations, the development of data models, minimum data sets and other activities. The Authorities need to continue to stay abreast of developments within CIHI, HL7 and other related initiatives. Adopting unique client, provider, and organization identifiers will also assist in linking client data.
- **Leverage relevant IM/IT initiatives**—The WCA and WHA should continue to forge linkages with Better Systems, the HIN and the Desktop Management (DTM) project, in order to leverage resources, skills, knowledge, purchasing power, infrastructure and to better support improved integration.
- **Prompt implementation**—The WCA and WHA have an urgent need for sophisticated information management tools. Therefore, these tools should be acquired and implemented as quickly as practical—and should be phased in, in a manner that enables demonstrable benefits to be achieved as soon as possible.
- **Retention and recruitment of IS staff**—In order to retain and recruit skilled Information Systems staff, senior management must ensure that the current IS staff understand that they have an important role in the new organization. Furthermore, the compensation for information systems staff must be competitive with the local market.

9. How to Proceed

The implementation of the information systems of the WCA and WHA will be one of the larger information systems projects in Manitoba. In order to ensure the success of this integrated project—in terms of on-time, on-budget completion, as well as the quality of the resulting IM/IT tools—the WCA and WHA must address a number of issues. These are described below.

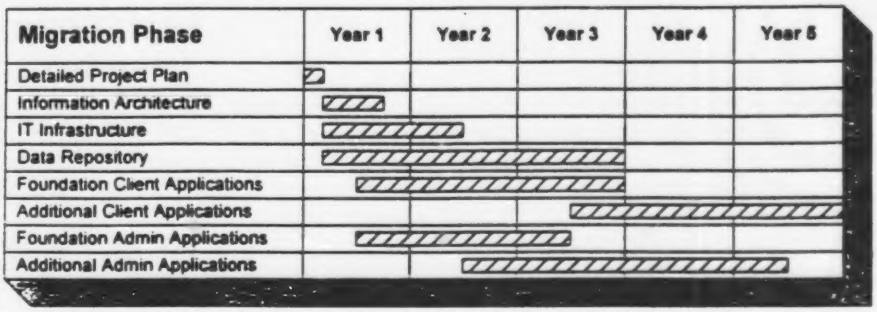
9.1 Information Systems leadership

- The WHA and WCA must recruit a suitably qualified IS leader as soon as possible. The IS leader must have a successful track record with projects of this magnitude—as well as the management of the IS function for a complex, multi-site organization
- The IS leader should report directly to the CEO's of the WCA and WHA.
- The IS leader must liaise closely with the CIO's of the Government of Manitoba and Manitoba Health, as well as with the rural RHA's, in order to foster collaboration and coordination of efforts.

9.2 Project planning and control

- The IS leader will develop an integrated project plan. This plan will be developed in consultation with appropriate support and clinical representatives of both the WCA and WHA, to ensure that both organizations' needs and priorities are addressed
- As illustrated in the diagram below, the project should be divided into a series of phases, to enhance project and budget control. For each phase, the project plan will identify:
  - Deliverables
  - Anticipated benefits and a plan to harvest them. This plan would address process optimization and staff training
  - Resources required
  - Timetable and milestones
  - Budget

Exhibit 3
Implementation Plan



10. Estimated Costs

Substantial investments in information technology and related services will be necessary to implement and support the information systems required by the two Authorities. These costs include one-time or capital costs and ongoing or operating costs. The capital costs will be spread over the five-year implementation time frame.

Capital costs include one-time costs for equipment (servers and end-user workstations), software, implementation, training and telecommunications.

Operating costs include ongoing costs for hardware and software support, ongoing training, technology renewal, telecommunications and the salaries of IT staff. Operating costs are likely to be at least four per cent of the operating budget of the WCA and WHA. As Michael Decter, the Chair of the Canadian Institute for Health Information recently noted: "Canada has badly under-invested in health information. We spend roughly two per cent of the total health budget on health information. We would get better value for our total health dollar if we increased that vital investment to four per cent." [3]

Clearly, the acquisition and ongoing operation of a suite of information systems for the WCA and WHA will be less costly if it is carried out jointly by the two organizations. Economies can be realized by means of more favourable contractual arrangements.

The estimated costs for **joint** acquisition and operation of information systems are as follows:

Capital costs:	$145 to $155 million
Operating costs:	$32 to $40 million per year

Cost savings from proceeding together: These figures indicate that, as a result of the two Authorities acquiring and implementing their systems jointly, the estimated capital costs will be up to $20 million less, and that the estimated operating costs will be up to $10 million less per year, than if they proceed independently.

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[3] Michael Decter, "Expert Evaluations," The Maclean's Health Report, June 15, 1998

Appendix F

A Unique Approach to Healthcare Restructuring and Reform

A Case Study

Mary Pat Skene

Mary Pat Skene

President and chief executive officer of St. Paul's Hospital, Saskatoon, and a certified executive member of the Canadian College of Health Services Executives (CCHSE), Mary Pat Skene (BScN, MEd) was elected to the board of the Catholic Health Association of Canada (CHAC) in 1996. This article is based on a paper Skene presented at the National Ethics Conference (Dec. 1-2, 1997), co-sponsored by the CHAC and the CCHSE.

> *"Whatever we do together is pure invention, the maps they gave us were out of date by years."...*
>
> Adrienne Rich
> (*Twenty-one Love Poems*, New York: Norton, 1978)

This truly captures how we felt as we entered into a joint service management partnership between Saskatoon District Health and St. Paul's Hospital. This partnership linked the Royal University, Saskatoon City and St. Paul's Hospitals into a developing network of integrated health services across the district, and complemented the consolidation of acute-care services that had commenced four years previously.

> **Like a delicate spiderweb with interconnected threads, our effectiveness and efficiency as a system depend on the strength of our attachment to one another.**

Basic to this partnership was the organization of patient/client care services into 12 "care groups," supported by district resource services. (Palliative Care Services and Surgical Care Services are examples of these care groups.)

Guiding Principles

To guide the development of our partnership, the following guiding principles were articulated, to which the boards put their signature in April 1996.

Work toward the development of a common direction
This principle was supported by the fact that the mission, vision and values of both organizations were in harmony (which helped us to work together), as well as by the relationship of trust demonstrated by the signing of a 10-year affiliation agreement (to the year 2005). Our mission and goals represent a promise to our communities.

Provide for the continuation of the mission and values of the Grey Nuns of Montreal (the owners of St. Paul's Hospital) **through ongoing mission education of all staff working at St. Paul's Hospital**

The "in-scope" staff who work at St. Paul's Hospital continue to be employees of the hospital, except when they must move between St. Paul's Hospital and the district, or when an integrated service is functioning on more than one site (e.g., Information Systems). "Out-of-scope" staff (such as managers) are accountable to the organization that manages the care group or district resource service.

This principle was very important to St. Paul's Hospital as the acute-care Catholic affiliate, because the dynamism and charism of our foundress, St. Marguerite d'Youville, energizes our organization.

Susan Wagner, chair, Saskatoon District Health Board, and Urban Donlevy, past chair, St. Paul's Hospital Board, signing guiding principles

Blend the existing workplace philosophies, to the greatest extent possible
The intent is to build on the strength, diversity and uniqueness of the partners within an interdependent model.

Form an integrated senior management team
This team, which included representatives from both the district and St. Paul's, brought the two management groups together and has resulted in mutual understanding and joint decision-making.

Assign the day-to-day management of shared services to the St. Paul's Board and the board of Saskatoon District Health
St. Paul's manages care groups and services across the district, and the district manages care groups and services within St. Paul's. This breaks down the barriers, as we work to achieve a seamless continuum of care.

Establish a "shared-service" committee to oversee these services
This committee includes the executives of both boards, and representation from the University of Saskatchewan's Health Sciences Disciplines. The committee's tasks are to: monitor performance; address concerns; and refer issues to mediation. To date, the latter has not been necessary.

> **Partnerships thrive on diversity. They require interdependence, which allows us to maintain our integrity and identity, but to come together to share in a common goal.**

Address financial accountabilities
The original principle was that the operating deficit/surplus would be the responsibility of the managing board. However, as we evolved and our integration progressed, it became necessary to re-examine this principle. Financial accountability now rests with Saskatoon District Health, in keeping with its legislated mandate for fiscal accountability for all health services within the district.

Manage capital assets (capital equipment and capital)These continue to be the accountability of the appropriate board, with priorities established on a system-wide basis.

Manage Foundation-purchased equipment
Since we continued to have separate Foundations, this principle addresses the transfer of Foundation-purchased equipment according to particular care groups and patient/client needs, resulting in an adjustment of assets.

Institute reporting procedures
Evaluate quarterly performance, do quality reporting and undertake ongoing reporting to both boards, as required.

Conduct an annual review of our partnership
In 1996, an amendment to Saskatchewan's Health District Act recognized affiliates in legislation and outlined defined requirements for operating agreements, one of which was an annual review.

We review our partnership annually. Fundamental to our partnership are the following beliefs:

- Partnerships are dynamic entities and are constantly evolving. They need to be based on trust and must be constantly nourished.
- Partnerships thrive on diversity. They require interdependence, which allows us to maintain our integrity and identity, but to come together to share in a common goal. Each of the partner's contributions towards that common goal are recognized as important.
- Partnerships require transformation. It is safe to say that none of us is the same as we were a year ago, prior to entering into this partnership.
- Partnerships require (among other qualities): sharing, commitment, dedication, credibility, cooperation, communication, courage and time. Like a delicate spiderweb with interconnected threads, our effectiveness and efficiency as a system depend on the strength of our attachment to one another.

[illegible] prior to entering into this partnership.

Goals of Our Partnership

Provide a seamless continuum of care
We wanted to put in place, first, a *form* that would follow the function we had articulated, which was to provide a continuum of care for the people within the Saskatoon Health District, as well as in the province.

Encourage stewardship: the wise use of resources
We wanted to avoid unnecessary duplication and blend the care groups and district resource services into a dynamic interdependent organization.

Improve planning, coordination and accountability for services
We adopted a system-wide approach to planning and coordination, which meant it was critical to determine who was accountable for what. The areas of shared accountability became and continue to be a key discussion point.

Enhance the ability of each board to fulfil its vision
The vision of St. Paul's and our owners, the Grey Nuns, is to be "vibrant and compassionate signs of hope in our broken world." We aim to strengthen our internal relationships, work in harmony with Saskatoon District Health, and form new relationships with community-based agencies and the people within the communities we serve.

The vision of Saskatoon District Health is to make a positive difference in the health of individuals, families, neighborhoods, communities, the district and the province by helping to achieve a balance and harmony in all aspects of living: physical, mental, social, cultural and spiritual.

Good Choices

As we apply our ethical framework, several "good choices" (outlined as follows) emerge.

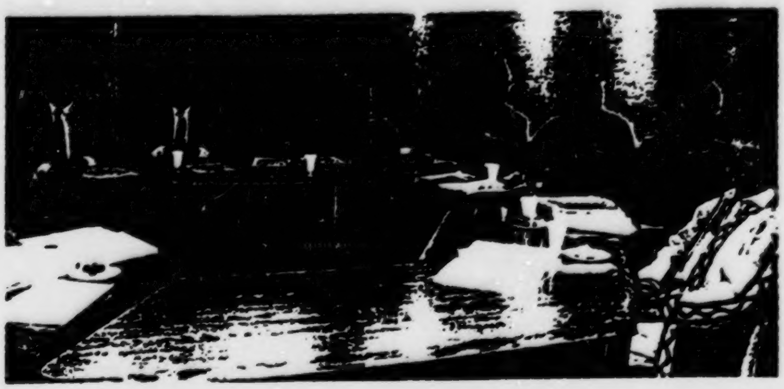
Influence of values
St. Paul's values are: respect for all, collaborative partnerships, holistic care, compassionate caring and stewardship. The district's values are: compassion, respect, trust, integrity and accountability.

The congruency of these values is obvious. They have influenced all dimensions of our partnership. For example, St. Paul's value of collaborative partnerships was a driving force in the decision to move forward with the present joint management partnership agreement.

A system designed around patient/client need
We are striving to have all of our decisions driven by the patient or the client, and not by the provider or the individual organization. In our recent accreditation, our long-term care or continuing-care team was noted as being "client-directed." This is our goal.

An integrated management approach
We brought the two senior leadership teams of both organizations together, to create a single team. This promoted and continues to promote mutual understanding and increased trust, and results in improved decision-making.

Integrated Senior Leadership Team Standing (left to right): Shan Landry, Dr. Bob Begg, Tom Archibald, Steve Hardcastle. Seated (left to right): Mary Pat Skene, president, St. Paul's Hospital; Jim Fergusson, president, Saskatoon District Health; Sharon Sullivan; Susan Bazylewski



Shared Service Committee with two board chairs. Far right: Susan Wagner, chair, Saskatoon District Health, and Monica Beavis, chair, St. Paul's Hospital

A shared-service committee

The formation of this committee, at the governance level, forged a link between the two boards, to address issues and plan together as we continue to evolve. This committee contributes significantly to our dynamic partnership.

A system-wide approach to the provision of care and to budgeting

In these times of rapid change – with healthcare reduction, restructuring and reform – it is very difficult to survive in isolation. By working together, we have found that we can improve health, both internally and externally. In fact, our slogan is: "Working together to improve health."

We have a three-pronged strategic plan: healthy communities, healthy operations and a healthy workplace. We are striving to have the healthiest community in Saskatchewan by the year 2000, supported by quality-focused, financially accountable operations – with committed, fulfilled staff, physicians and volunteers.

Decentralized, information-based decision-making

As we develop our databases system-wide, and our performance and quality indicators, we are able to make evidence-based decisions.

Focus on outcomes

Key to this is the identification and clarification of required outcomes, along with indicators that measure progress towards the achievement of these outcomes. For example, one major outcome is to become the healthiest community in Saskatchewan by the year 2000.

An interdisciplinary approach

Basic to our care group model is an *interdisciplinary* approach. This approach reflects *all* of us – staff, physicians and volunteers, along with patients, clients and their families – working together towards the same goal: quality patient care. To achieve this, we need to have a mutual understanding of and respect for each other's roles.

Organizational streamlining and interdependence

A significant part of the *restructuring* component of healthcare reform in our district has been the need to streamline our organizations, remove unnecessary duplication and focus on our patients/clients. Within our joint service management partnership we have significantly reduced the number of senior administrative positions and attempted to place the emphasis on our front-line caregivers.

Interdependence

Partnerships require interdependence. We are striving to move from independence to an *inter*dependent reality. Within our partnership this means building on the strength and diversity of individuals and groups, in order to make a positive difference in the health of our community.

Ethical Challenges

Our unique approach is not without ethical challenges. These are outlined as follows.

The move from control to influence

This is our first challenge, particularly for the affiliate, although it works both ways. We agree that, as the affiliate, St. Paul's Hospital will be involved in the decision-making process with Saskatoon District Health and the province, as appropriate – with the clear understanding that the intent would be to obtain input and clarification. Saskatoon District Health is provided the same opportunity in decisions made by the St. Paul's Hospital Board.

Opening of native prayer & ceremonial room, with a gathering for a pipe ceremony

Cutting the 90th anniversary birthday cake with Saskatchewan Premier Roy Romanow

Shared accountability
Although we can clearly identify primary accountabilities and, with some success, secondary accountabilities, when we are dealing with *shared* accountability it can become difficult. For example, vice-presidents report through each of the presidents to *both* boards, according to the issue and the area of accountability.

The bridge to trust
This is a significant challenge. Bridges are difficult to build, very fragile and can be easily destroyed. They also take time and nurturing. The development of trust was facilitated by the formation of a senior leadership team, as well as by the contributions of the Shared Service Committee.

Decision-making
This is the next challenge. Who makes the *final* decision? We consulted the legislation for clarity. While the Health Districts Act of Saskatchewan clearly puts decision-making for the health status of the community and for fiscal challenges with the district (e.g., final decisions on mental health service or decisions regarding the allocation of resources), the *affiliate* remains accountable to the appropriate sponsorship/ownership group for the mission, vision and values. The creation of a native prayer and ceremonial room at St. Paul's Hospital and the celebration of the 90th anniversary of St. Paul's Hospital are examples of this type of accountability.

In both cases, we firmly believe that decisions based on *consultation* are better decisions. Therefore, we promote consultations by the district with St. Paul's, and by St. Paul's with the district, as we make decisions.

Uncertainty
The challenge of uncertainty causes heartache and moral distress. There is no right answer. Our mission, vision and values must drive us so that, based on our best information, we make decisions and move forward – despite the fact that we are "creating our own roadmap" as we go.

The joint-service management partnership between Saskatoon District Health and St. Paul's Hospital – conceptualized by the current leaders of both organizations – is a relationship-based model which needs to be vested in the *organization*, not in individuals. Our challenge will be to vest this model in our *organizations*, so they will not be individual-dependent, as we move into the next millennium.

Manitoba Government
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May 9, 2000

WEBSTER REPORT RELEASED

BY HEALTH MINISTER

Health Minister Dave Chomiak today released the Health Care Financial Management and Accountability Review.

"We have received the report and the department is reviewing it. We are releasing it today so that we can continue the dialogue on health care improvements," Chomiak said.

Gordon Webster was appointed to lead the review set in motion in November 1999 by Chomiak and Finance Minister Greg Selinger. This process was intended to recommend cost control and management measures for the Department of Health and the regional health authorities while preserving services to the public.

"Our government is committed to improving the quality of health care for Manitobans by ensuring health care dollars are spent on front- line delivery and not increased administrative cost," Chomiak said. "We have a lot of work ahead of us, but have already started to achieve some positive results in increasing the efficiency and effectiveness of our health care system."

To date, this government has taken the following actions toward improving financial accountability in the health care system:

- Amalgamated the Winnipeg Long-term Care Authority and Winnipeg Hospital Authority to reduce administrative duplication.
- Taken control of the Urban Shared Services Corporation (USSC) contract, set up a working group to review shared food services issues and made USSC part of the Winnipeg Regional Health Authority effective April 1. The goal was not only to have nutrition experts and front-line clinical staff making recommendations on food, but also to put financial controls and accountability back into the process.
- Ended the SmartHealth project due to disappointing progress. The government is currently reviewing other, more effective computer-based management and clinical health information systems.
- Provided regional health authorities with workable funding guidelines to use in developing operating budgets in time for the upcoming fiscal year. This has helped them engage in both more accurate and earlier planning. Funding commitments traditionally have been provided well into the fiscal year, making it difficult for them to manage.

- Aggressively pursued discussions with the federal government regarding the need for improved financial support.

"While we look forward to comments and suggestions about the report, it is clear that we have already made progress on some of the recommendations," Chomiak said. "This report is just one of many resources we will be using to put our financial house in order, and to improve the management of the health care system. That is the best long-term strategy for ensuring Manitobans continue to receive the high quality of health care they deserve."

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RETURN